DOCUMENT RESUME

ED 298 393 CG 021 074

AUTHOR	Hammett, Theodore M.
TITLE	AIDS in Correctional Facilities: Issues and Options. Issues and Practices in Criminal Justice. Third Edition.
INSTITUTION	Abt Associates, Inc., Washington, DC.
SPONS AGENCY	Department of Justice, Washington, D.C. National Inst. of Justice.
PUB DATE	Apr 88
CONTRACT	OJP-86-C-002
NOTE	279p.
PUB TYPE	Reports - General (140)
EDRS PRICE	MF01/PC12 Plus Postage.
DESCRIPTORS	*Acquired Immune Deficiency Syndrome; *Correctional Institutions; *Criminals; *Policy; *Prisoners

ABSTRACT

This document, written for officials involved in making and implementing decisions regarding the correctional response to Acquired Immune Deficiency Syndrome (AIDS), provides the most current figures and trend data on the incidence of AIDS among incarcerated offenders. The stated purpose of this document is to be informational rather than prescriptive. It reviews both the policy options and the range of correctional practice with respect to testing, housing, medical care, and education programs. Current information on costs is summarized and the status of relevant legal issues and recent litigation is discussed. Data presented in the document were gathered from these sources: responses to a national mail questionnaire; site visits to five correctional systems; aggregate data from the Centers for Disease Control; interviews with medical authorities and correctional officials; and an extensive literature review. Chapter topics include: (1) essential medical information; (2) the epidemiology of human immunodeficiency virus (HIV) infection and AIDS in correctional facilities and the population at large; (3) education and training; (4) HIV antibody screening and testing; (5) medical, psychosocial, and correctional management issues; and (6) confidentiality, legal issues, and labor relations issues. Appendices include Centers for Disease Control guidelines, examples of correctional AIDS policies, and a resource list. (ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. Department of Justice
National Institute of Justice

National Institute of Justice / *Issues and Practices*

ED298393

CG 021074

AIDS in Correctional Facilities:

Issues and Options

Third Edition

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

About the National Institute of Justice

The National Institute of Justice is a research branch of the U.S. Department of Justice. The Institute's mission is to develop knowledge about crime, its causes and control. Priority is given to policy-relevant research that can yield approaches and information that State and local agencies can use in preventing and reducing crime. The decisions made by criminal justice practitioners and policymakers affect millions of citizens, and crime affects almost all our public institutions and the private sector as well. Targeting resources, assuring their effective allocation, and developing new means of cooperation between the public and private sector are some of the emerging issues in law enforcement and criminal justice that research can help illuminate.

Carrying out the mandate assigned by Congress in the Justice Assistance Act of 1984, the National Institute of Justice:

- Sponsors research and development to improve and strengthen the criminal justice system and related civil aspects, with a balanced program of basic and applied research.
- Evaluates the effectiveness of justice improvement programs and identifies programs that promise to be successful if continued or repeated.
- Tests and demonstrates new and improved approaches to strengthen the justice system, and recommends actions that can be taken by Federal, State, and local governments and private organizations and individuals to achieve this goal.
- Disseminates information from research, demonstrations, evaluations, and special programs to Federal, State, and local governments, and serves as an international clearinghouse of justice information.
- Trains criminal justice practitioners in research and evaluation findings, and assists practitioners and researchers through fellowships and special seminars.

Authority for administering the Institute and awarding grants, contracts, and cooperative agreements is vested in the NIJ Director. In establishing its research agenda, the Institute is guided by the priorities of the Attorney General and the needs of the criminal justice field. The Institute actively solicits the views of police, courts, and corrections practitioners as well as the private sector to identify the most critical problems and to plan research that can help solve them.

James K. Stewart
Director

U.S. Department of Justice
National Institute of Justice
Office of Communication and Research Utilization

AIDS in Correctional Facilities:
Issues and Options

Third Edition

by

Theodore M. Hammett

with assistance from
Saira Moini

First Edition: April 1986
Second Edition: May 1987
Third Edition: April 1988

Issues and Practices in Criminal Justice is a publication series of the National Institute of Justice. Designed for the criminal justice professional, each *Issues and Practices* report presents the program options and management issues in a topic area, based on a review of research and evaluation findings, operational experience, and expert opinion on the subject. The intent is to provide criminal justice managers and administrators with the information to make informed choices in planning, implementing and improving programs and practice.

Prepared for the National Institute of Justice, U.S. Department of Justice by Abt Associates Inc., under contract #OJP-86-C-002. Points of view or opinions stated in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Advisory Panel

Ford Brewer, M.D.
Chief Medical Officer
Maryland Division of Correction
Baltimore, MD

Frank Gunter
Director
Nebraska Department of Correctional Services
Lincoln, NE

Nadim Khoury, M.D.
Medical Director
California Department of Corrections
Sacramento, CA

Raymond Broaddus, Ph.D.
Assistant Commissioner for Health Services
New York Department of Correctional Services
Albany, NY

Harold Jaffe, M.D.
Chief, Epidemiology Branch
AIDS Program
Center for Infectious Diseases
Centers for Disease Control
Atlanta, GA

Beverly Marable
Public Affairs Officer
Maryland Division of Correction
Baltimore, MD

Program Monitor

Cheri Crawford
National Institute of Justice
Washington, DC

National Institute of Justice
James K. Stewart
Director

The Assistant Attorney General, Office of Justice Programs, coordinates the activities of the following program Offices and Bureaus: National Institute of Justice, Bureau of Justice Statistics, Bureau of Justice Assistance, Office of Juvenile Justice and Delinquency Prevention, and Office for Victims of Crime.

Foreword

The managers and staff of correctional institutions were among the first criminal justice professionals to confront the problem of coping with AIDS. Time has not diminished that challenge. By October 1987, a cumulative total of 1,964 confirmed AIDS cases had been reported among inmates in the nation's prisons and its largest jails — an increase of 156 percent over the first survey of inmate AIDS cases in 1985. (That staggering increase is still less than the 187 percent increase in confirmed AIDS cases among the general population during the same time period.) Correctional administrators thus continue to face tough decisions about institutional management, the best and most equitable means of identifying and treating inmates with AIDS, potential legal issues, and the costs of medical care. Policymakers and corrections officials cannot afford to wait until medical science produces an ultimate answer. To effectively address the problem today, they need the most accurate and up-to-date information available.

In late 1985, the National Institute of Justice (NIJ) began its first study of AIDS in prisons and jails and has, since then, annually surveyed and reported on the incidence and institutional management of AIDS within the federal and state prison systems as well as in the nation's largest jails. Over 8,000 copies of the first and second editions, and the 1986 Update have been distributed on request to date. This document, the third edition of *AIDS in Correctional Facilities: Issues and Options*, represents a complete revision of the original report. It provides the most current figures and trend data on the incidence of AIDS among incarcerated offenders. It reviews both the policy options and the range of correctional practice with respect to testing, housing, medical care, and education programs. Current information on costs is summarized and the status of relevant legal issues and recent litigation is discussed.

This report is but one part of NIJ's ongoing effort to assist correctional administrators and other criminal justice professionals in meeting the challenge of AIDS. NIJ's *AIDS and the Law Enforcement Officer: Concerns and Policy Responses*, examines AIDS-related policies, training programs, and appropriate precautionary measures in the context of current medical knowledge and the day-to-day realities of law enforcement. A study now underway is examining the issues which AIDS raises for probation and parole professionals.

In mid-1987, the Institute also established the NIJ AIDS Clearinghouse to provide a centralized national source of information about how AIDS affects criminal justice professionals and their work. Within the first two months of operation, the Clearinghouse received over 700 calls and requests from federal, state and local criminal justice agencies. The Clearinghouse gathers and disseminates AIDS-related information developed by NIJ, the Centers for Disease Control, other agencies of the U.S. Public Health Service, and the Department of Justice, as well as selected materials prepared by professional organizations, state and local governments, and criminal justice agencies throughout the U.S. As part of the Clearinghouse, NIJ instituted a new publication series, *AIDS Bulletin* — short, nontechnical summaries of AIDS-related criminal justice topics.

The HIV epidemic places enormous stress on already overburdened correctional systems. Current and accurate information can place corrections officials in a stronger position to address the problem of AIDS, provide sound education and training, ensure equitable delivery of services, and develop reasoned and effective management policies. Correctional administrators and managers have already done much to meet the challenge of AIDS. The National Institute of Justice hopes that this volume will be of assistance in their continued efforts.

James K. Stewart
Director
National Institute of Justice

Acknowledgements

Many people contributed a great deal of time and energy to preparing the third edition of this work, and it is a pleasure to acknowledge them here.

The staff of Abt Associates' Law and Justice Area deserve a great deal of thanks for their efforts. Saira Moini assisted with all aspects of the project, including organization and supervision of the national survey, data coding, and preparation of a draft chapter. Joan Mullen reviewed and significantly improved several drafts of the report. Susan McWhan ably assisted with many project tasks, including survey followup, data coding, and analysis. Sarah Colson and Felicia Hayes oversaw production of the report and Mary-Ellen Perry, Andy Blickenderfer, and Ellen Kaplan-Maxfield provided expert word-processing services.

Our project monitors at the National Institute of Justice—Cheryl Crawford and Virginia Baldau—provided indispensable encouragement, assistance and substantive input throughout the preparation of this edition. They carefully reviewed drafts of the questionnaire and report, and offered numerous valuable suggestions.

The project advisory panel provided important suggestions and comments on the report. It was composed of the following individuals: Dr. Ford Brewer, Chief Medical Officer, Maryland Division of Correction; Dr. Harold Jaffe, Chief, Epidemiology Branch, AIDS Program, Centers for Disease Control; Frank Gunter, Director, Nebraska Department of Correctional Services; Dr. Raymond Broaddus, Assistant Commissioner for Health Services, New York Department of Correctional Services; Dr. Nadim Khoury, Medical Director, California Department of Corrections; and Beverly Marable, Public Affairs Officer, Maryland Division of Correction.

This project could not have been completed without the cooperation of several hundred correctional administrators, correctional medical directors, correctional legal counsel, physicians, researchers and others who responded to our questionnaires, answered our followup questions and provided other invaluable information. They were unfailingly gracious and patient.

In particular, I would like to thank the administrators and staff of the correctional systems in which we conducted site visits: Arnold Hopkins, Commissioner, Maryland Division of Correction; Michael Hennessey, San Francisco County Sheriff; Lt. Jan Dempsey, Training Director, San Francisco County Sheriff's Department and Rallé Greenberg, Forensic AIDS Project, San Francisco Department of Public Health; Dr. Nadim Khoury, Medical Director, California Department of Corrections and Chris Cummings, Health Programs Advisor; George Sumner, Director, Nevada Department of Prisons, and Catherine Lowe, Medical Administrator, and Thomas Coughlin, Commissioner, New York Department of Correctional Services, and Saundra Johnson, Communicable and Infectious Disease Coordinator. All of these individuals were extremely cooperative and helpful to us.

Theodore M. Hammett
March 1988

Table of Contents

Page

FOREWORD iii
ACKNOWLEDGEMENTS v
LIST OF FIGURES x
INTRODUCTION AND SUMMARY xi

Purposes of this Document xi
Intended Audiences for this Document xi
Study Methodology xi
AIDS in Correctional Facilities: Key Issues and Organization of the Report xii
  The Problem of AIDS xii
  Key Issues in Developing Correctional Policies and Procedures xiii
  Key Policy Options xiii

PART ONE THE PROBLEM OF AIDS

CHAPTER 1 ESSENTIAL MEDICAL INFORMATION 3

The Cause of AIDS: Human Immunodeficiency Virus 3
HIV Antibody Test and Their Applications 3
Definitions 4
  AIDS ("end-stage") 4
  AIDS-Related Complex (ARC) 5
  Asymptomatic HIV Infection 5
The Relationships Among Exposure, Infection, HIV Seropositivity, and Development of ARC or AIDS 5
Incubation Period of AIDS 7
Survival with AIDS 7
Transmission of HIV Infection 8
  Known Means of Transmission: Sexual Contact, Inoculation of Blood, and Perinatal Events 8
  No Transmission Through Casual Contact 15
  No Transmission in Social or Occupational Settings 15
  Evidence Against Transmission Through Other Body Fluids and Through Biting Incidents 15
  Evidence Against Transmission by Insects 16
Prospects for Vaccines and Cures 17

CHAPTER 2 THE EPIDEMIOLOGY OF HIV INFECTION AND AIDS IN CORRECTIONAL FACILITIES AND THE POPULATION AT LARGE 21

HIV Infection and AIDS in the Population at Large 21
HIV Infection and AIDS in Correctional Facilities 22
  No Job-Related Cases of HIV Infection or AIDS Among Correctional Staff 22
  AIDS Cases Among Correctional Inmates 23
  Characteristics of Inmate AIDS Cases 26
  AIDS-Related Complex (ARC) Among Correctional Inmates 28
  HIV Seroprevalence Among Correctional Inmates 28
  Transmission of HIV Infection in Correctional Institutions 29

Page

PART TWO POLICY OPTIONS FOR CORRECTIONAL ADMINISTRATORS

CHAPTER 3 EDUCATION AND TRAINING 39

- Overview of the Issues and NIJ Survey Results 39
- Effects of Education and Training on Inmates and Staff 41
- Key Elements of Education and Training Programs for Inmates and Staff 42
  - Timely Education and Training 42
  - Regular Education and Training 42
  - Mandatory Education and Training 43
  - Strong Executive and Management Commitment to Education and Training 44
  - Staff and Inmate Participation in Development of Education Programs 44
  - Live Education and Training 45
  - Other Modes of Presentation 45
  - Simple and Straightforward Messages 47
  - Credibility 47
  - Avoiding Extremes of Alarmism and Complacency 49
  - Training Keyed to Specific Concerns of Correctional Audiences 49
  - Content of AIDS Education and Training 50
  - Documenting Traing Attendance and Receipt of Educational Materials 55
  - Evaluating Education and Training 55
- Conclusion 56

CHAPTER 4 HIV ANTIBODY SCREENING AND TESTING 59

- Mass Screening for Antibodies to HIV: The Debate 59
  - Are HIV Antibody Tests Reliable and Accurate? 61
  - Can Mass Screening Prevent Transmission of HIV? 65
  - Will Mass Screening Improve Medical Monitoring and Care? 66
  - Is It Possible to Maintain the Confidentiality of Antibody Test Results in Correctional Facilities, and How Does Disclosure Affect Seropositive Inmates? 66
  - What Are the Legal Implications of Mass Screening? 67
  - How Costly Are Mass Screening Programs? 67
  - Will Mass Screening Support or Undermine the Effects of Education and Prevention Programs? 68
  - Will Mass Screening Allay or Inflame the Fears of Inmates, Staff, and the Public? 68
  - Is Mass Screening the Best Way to Assess the Extent of the AIDS Problem in an Inmate Population? 69
  - Should Correctional Systems Be Taking Steps Not Taken in Society at Large? 69
- Summary of NIJ Survey Results 70
- Other Applications of HIV Antibody Tests 71
  - Testing Inmates with Histories of High-Risk Behavior 72
  - Testing in Response to Potential Transmission Incidents 73
  - Voluntary Testing 73
  - Testing on Request 74
  - Testing in Support of Epidemiological Studies 74
  - Testing of Correctional Staff 74
- Who Receives Test Results? 74
- Conclusion 74

Page

CHAPTER 5 MEDICAL, PSYCHO-SOCIAL, AND CORRECTIONAL MANAGEMENT ISSUES 79

- Medical and Psycho-Social Services 79
  - Detection, Diagnosis and Medical Surveillance 79
  - Medical Treatment 80
  - Counseling and Other Psycho-Social Services 80
  - Pre-Release Planning and Aftercare 81
  - Costs of Care and Associated Services 81
- Housing Policies for Inmates with AIDS, ARC, or Asymptomatic HIV Infection 82
  - Overview of NIJ Survey Results 83
  - Major Housing Options 84
- Precautionary and Preventive Measures 89
  - Universal Precautions 89
  - Judgment in Implementation 90
  - Response to Specific Situations 90
  - Unnecessary Preventive Measures 91
  - Restrictions on Inmate Visitation Privileges 92
  - Availability of Condoms for Inmates 92
- Conclusion 92

CHAPTER 6 CONFIDENTIALITY, LEGAL AND LABOR RELATIONS ISSUES 95

- Notification and Confidentiality 95
  - Overview of NIJ Survey Results 95
  - Range of Options Regarding Who Receives Information 95
  - Danger of Disclosure to Other Inmates 99
- Legal and Labor Relations Issues 99
  - Issues Raised by Inmates 99
  - Issues Raised by Both Inmates and Staff: Protection from HIV Infection 103
  - Issues Raised by Staff 106
- Legislative Developments 107
- Conclusion 108

APPENDIX A: Resource List 113

APPENDIX B: Definitions of AIDS and AIDS-Related Complex 119

APPENDIX C: List of City and County Jail Systems and Canadian Systems Responding to the NIJ Survey 135

APPENDIX D: Training, Education and Counseling Materials 139

APPENDIX E: CDC Guidelines 217

APPENDIX F: Forms for Inmate Screening and History Taking 241

APPENDIX G: Examples of Correctional AIDS Policies 251

APPENDIX H: HIV Antibody Test Consent Form 283

List of Figures

Page

Figure 1.1 Relationships Among Exposure, Infection, HIV Seropositivity, ARC, and AIDS....... 6
Figure 1.2 Known Routes of HIV Transmission........ 8
Figure 1.3 Risk of Infection Through Specific Means of HIV Transmission........ 9
Figure 2.1 Breakdown of Adult/Adolescent AIDS Cases in the U.S. by Transmission Categories........ 22
Figure 2.2 Cumulative Total AIDS Cases Among U.S. Correctional Inmates and the U.S. Population at Large, 1985-1987........ 23
Figure 2.3 Distribution of Confirmed AIDS Cases Among Inmates, by Type of System, United States........ 24
Figure 2.4 Distribution of Cumulative Total AIDS Cases, October 1987, Across State/Federal Prison Systems........ 25
Figure 2.5 Distribution of Cumulative Total AIDS Cases, October 1987, Across City/County Jail Systems........ 26
Figure 2.6 Regional Distribution of Total AIDS Cases by Type of System, United States (Federal Bureau of Prisons Excluded)........ 27
Figure 2.7 Results of Mass Screening Programs in Correctional Facilities........ 29
Figure 2.8 Results of "Risk-Group" Screening Programs in Correctional Facilities........ 30
Figure 2.9 Results of Blind Epidemiological Studies in Correctional Facilities........ 30
Figure 2.10 Results of Other HIV Antibody Testing Programs in Correctional Facilities........ 31
Figure 3.1 Modes of AIDS Training Presentation for Staff........ 40
Figure 3.2 Modes of AIDS Training Presentation for Inmates........ 40
Figure 3.3 Appropriate Educational and Action Messages to Address AIDS-Related Concerns of Correctional Personnel........ 50
Figure 4.1 Correctional Systems with Mass Screening or Risk-Group Screening Programs, October 1987........ 60
Figure 4.2 Hypothetical HIV Antibody Screening in a Population of 500 with a 20% True Prevalence of Infection........ 62
Figure 4.3 Hypothetical HIV Antibody Screening in a Population of 500 with a 1% True Prevalence of Infection........ 63
Figure 4.4 Hypothetical Application of Mass Screening for Antibodies to HIV in a Population of 25,000 Inmates........ 64
Figure 4.5 Summary of Responding Jurisdictions' Policies on HIV Antibody Testing of Inmates........ 71
Figure 4.6 Mutually Exclusive Categorization of Responding Jurisdictions' Screening/Testing Policies for Inmates........ 72
Figure 5.1 Housing Policies for Inmates with AIDS, ARC, and Asymptomatic HIV Infection: State and Federal Prison Systems........ 83
Figure 5.2 Housing Policies for Inmates with AIDS, ARC, and Asymptomatic HIV Infection: City and County Jail Systems........ 84
Figure 5.3 Housing Policies for Inmates with AIDS, ARC, and Asymptomatic HIV Infection: Canadian Systems........ 85
Figure 5.4 Housing Policy Combinations........ 86
Figure 5.5 Written Precautionary Policies in Correctional Systems........ 90
Figure 6.1 Policies Regarding Disclosure of Inmates' HIV Antibody Test Results........ 96

Introduction and Summary

Acquired Immunodeficiency Syndrome (AIDS) has become a major policy and management issue for correctional administrators in the United States and Correctional institutions have become a focus of concern about this disease. This has been due to perceptions that prisons and jails hold high concentrations of individuals at risk of developing AIDS as a result of prior intravenous drug abuse and that correctional inmates frequently engage in behaviors likely to spread the disease—particularly homosexual activity.

Purposes of this Document

This document is intended to be informational rather than prescriptive. The issues affecting the correctional response to AIDS are too complex for simple policy formulas. In the two years since the first edition of this report appeared, most correctional systems have adopted policies regarding AIDS. Certain principles, such as the importance of inmate and staff education on AIDS, are indisputable. However, many key policy issues—particularly HIV antibody testing, housing of infected inmates, and precautionary measures—continue to spark controversy both within and outside correctional systems. Correctional systems have often found themselves under political pressure to adopt certain policies. The National Institute of Justice has sponsored this entirely revised edition of the report to respond to the continuing needs of correctional administrators for up-to-date information as they address a range of difficult and complex policy issues. The following categories of information appear to be in particular demand:

- up-to-date medical and epidemiological facts on AIDS;
- concise statements of the major facts and issues affecting the correctional response to AIDS;
- a broad base of information on AIDS-related policies and procedures currently in force or in development in correctional systems nationwide; and
- delineation of the range of specific policy options available to administrators for dealing with this complex and difficult problem.

This document seeks to provide these types of information and to present as fairly and objectively as possible the rationales advanced for various policy options. It is also hoped that the report will facilitate information exchange across jurisdictions and, ultimately, the development of consensus on the most effective and appropriate policies and procedures for addressing AIDS in correctional facilities.

Intended Audiences for this Document

This document is directed to all officials who may be involved in making and implementing decisions regarding the correctional response to AIDS. This includes the following groups: correctional commissioners; other correctional administrators at both the departmental and institutional levels; correctional medical directors and other medical staff at both the departmental and institutional levels; public health authorities; legal staff of correctional departments; and legislators and other decisionmakers considering laws or policy initiatives related to AIDS in correctional facilities—e.g., budgets for prison construction and staffing and laws or policies requiring confidentiality of AIDS-related medical information.

Study Methodology

The data and information presented in this report were gathered from the following major sources:

- responses to a national mail questionnaire;
- site visits to five correctional systems with varying policies regarding AIDS;
- aggregate data provided by the Centers for Disease Control (CDC);
- interviews with medical authorities and correctional officials; and
- an extensive literature review.

A mail questionnaire was sent to the correctional departments of all fifty states, the federal prison system, thirty-seven large city and county jail systems, and twelve Canadian systems. (A list of the city and county jail systems and Canadian correctional systems who responded to the questionnaire is included in Appendix C.) The questionnaire included basic questions on inmate population, numbers of inmate cases of AIDS and ARC, and aggregate results of HIV antibody testing programs, as well as a series of questions on major policies regarding AIDS (training and education, testing, medical and psycho-social services, housing, precautionary measures, confidentiality) and associated legal and cost issues. We obtained an overall response rate of 96 percent to the questionnaire: 100 percent for states and the federal system; 89 percent for city/county systems; and 100 percent for Canadian systems. Following extensive telephone callbacks to respondents to clarify answers, the questionnaires were coded and analyzed using the microcomputer version of the Statistical Package for the Social Sciences (SPSS/PC). All data in this report are current as of October 1987 - December 1987, the period during which all questionnaire responses were prepared.

Questionnaire respondents were assured that data on the numbers of AIDS and ARC cases would not be reported by state or jurisdiction. Thus, we do not identify particular numbers of cases with particular jurisdictions. Moreover, respondent jurisdictions were given the option of remaining fully anonymous—that is, of not being identified in the report in connection with any policy, procedure, or piece of information. Several respondents chose full anonymity. This explains why some policies, procedures, and items of information mentioned in the report are not associated with named jurisdictions.

The project made extensive use of CDC aggregate data on AIDS case reports. These data form the basis of the summary epidemiological profile of AIDS and the AIDS incidence rates for the population at large which are presented in the report. Project staff interviewed numerous physicians, medical researchers, correctional administrators, public health officials, attorneys, and others to gather information on key issues and options. Finally, project staff reviewed a great deal of scientific literature, educational material, correctional and public health procedures, and newspaper and magazine articles. We made use of several automated database searches to ensure that we had identified all relevant literature and articles.

AIDS in Correctional Facilities: Key Issues and Organization of the Report

This section summarizes key facts and issues regarding AIDS in the correctional setting—with reference to the subsequent chapters that will provide detailed discussions.

The Problem of AIDS

Chapter One of this report summarizes the latest medical information and research on AIDS. AIDS is a serious communicable disease that undermines the human body's ability to combat infections and malignancies. In 1983 and 1984, the cause of AIDS—now called human immunodeficiency virus (HIV)—was discovered by scientists. Most cases in the United States have been among homosexual men and intravenous drug abusers, although heterosexual transmission has been clearly documented and the number of heterosexually transmitted cases has grown at a more rapid rate than cases in other transmission categories. End-stage AIDS is a fatal disease. However, there is a range of milder forms of illness, sometimes called AIDS-related complex (ARC), that may also appear among those infected with the AIDS virus.

Infection with HIV is transmitted through contaminated blood, semen, and vaginal secretions, primarily during sexual intercourse and needle-sharing related to intravenous drug abuse. The virus is difficult to transmit and there is absolutely no evidence of its transmission through any form of casual contact.

In 1985, tests became available to detect the presence of antibodies (evidence of the body's attempts to fight off an infection) to HIV. However, the test does not detect the presence of the virus itself and there continues to be substantial debate surrounding the appropriate uses of the antibody tests and the accuracy of their results. While significant progress has been made in medical research on AIDS, there is still no vaccine or generally effective therapy for HIV infection.

Chapter Two presents the epidemiology of AIDS in the correctional setting and the outside world. On January 4, 1988, the 50,000th case of AIDS was reported in the United States. Cases are still concentrated in large metropolitan areas on the east and west coasts, but the distribution is less skewed than it was in 1985. Responses to the NIJ survey reveal that, as of October 1987, there have been a cumulative total of 1,320 confirmed AIDS cases in thirty-nine state and federal correctional systems. In addition, thirty-one large city and county jail systems reported a cumulative total of 644 cases of AIDS among inmates. Thus, survey responses from the United States reveal a total of 1964 correctional AIDS cases. There have been a cumulative total of fifteen AIDS cases reported among Canadian inmates. There have been *no* job-related cases of HIV infection or AIDS among correctional staff.

Inmate cases have increased by 156 percent since the first NIJ survey in 1985 and by 59 percent since the second survey in 1986. These are large increases, but the 1986-87 increase is, in fact, slightly lower than that in the American population as a whole over the same period (61 percent). These figures represent *cumulative* total cases since the responding jurisdictions began keeping records. According to questionnaire responses, as of October 1987, there were 295 *current* cases of AIDS among state and federal inmates in thirty-nine systems and 126 *current* cases among city and county inmates in thirty-one systems. There were four cases in Canadian systems. The majority of correctional AIDS cases are believed to be associated with intravenous drug abuse. This association is particularly strong in the Middle Atlantic region.

The distribution of AIDS cases across correctional systems is quite uneven, although less so than two years ago. More than 70 percent of state/federal prison systems and almost two-thirds of city/county systems have had fewer than ten cases. At the other extreme, four state and federal systems (8 percent) have had 73 percent of the cases in those systems and four of the responding city and county systems (12 percent) had 67 percent of the cases in those systems.

AIDS incidence rates are higher in the correctional setting than in the population at large. This is almost certainly due to the higher concentrations of high-risk group members (particular intravenous drug abusers) in inmate populations than in the population at large. There is substantial debate, but little hard data, on the extent to which the AIDS virus is being transmitted within correctional institutions. Data from several jurisdictions suggest low rates of transmission. However, logic and common sense suggest that, even in the best-managed correctional facilities, there may be at least some transmission of the infection occurring among inmates.

Key Issues in Developing Correctional Policies and Procedures

Part Two of the report covers the following major policy areas: Education and Training (Chapter Three); HIV Antibody Screening and Testing (Chapter Four); Medical, Psycho-Social, and Correctional Management Issues (Chapter Five), and Confidentiality, Legal, and Labor Relations Issues (Chapter Six). The following issues affect decisionmaking in all of these major policy areas:

- *The importance of education and training.* Effective educational programs, which address identified concerns and present rational and practical measures to minimize risk, can dramatically reduce the fears of inmates and staff and thereby influence a whole range of policy options regarding housing, work assignments, and the daily routine of the correctional institution.
- *The relative importance of medical and correctional considerations in reaching policy decisions.* Administrators must decide among sometimes conflicting advice based on medical guidelines designed for the outside community, on the one hand, and the special circumstances of the correctional institution, on the other. Such conflicts may affect decisions regarding testing, housing, medical management, and precautionary measures.
- *The extent and nature of the correctional system's responsibilities for preventing the transmission of HIV infection and AIDS.* This issue requires administrators to decide whether their institutions should bear responsibilities for disclosure of information and other precautionary measures that are not practiced in the community at large. This, in turn, depends on deciding whether there is more intrinsic risk that the disease will be transmitted in the correctional setting than in other settings in the outside world.
- *The inter-relatedness of many key AIDS-related policy decisions.* Administrators should consider the "big picture" of AIDS policy, because each individual policy decision (such as whether to conduct mass HIV antibody screening) may drive others (such as housing for seropositives and notification/disclosure of inmates' antibody status when paroled or released).

Key Policy Options

This section summarizes the findings and recommendations of the chapters on key policy options. These summaries are drawn from the concluding section of each chapter.

Education and Training

Chapter Three discusses education and training on AIDS for correctional staff and inmates. Education and training represent the keystone of the correctional response to AIDS. Virtually all responding correctional systems are now providing some AIDS education to both inmates and staff. Live training has become much more prevalent in the two years since the first NIJ study. Education and training are particularly necessary because of the persistence of misinformation, as well as rational concerns, regarding AIDS. Our survey results show that staff and inmate concern about AIDS have *not* declined significantly in the last year.

Chapter Three discusses the following key elements of AIDS education and training:

- AIDS training should be timely—if possible, it should be presented before widespread concern takes hold.
- AIDS training should be regularly presented and regularly updated to respond to changing information and the often misleading media coverage of AIDS. Misinformed fear will reassert itself without frequent doses of accurate medical information.
- AIDS training should be mandatory for inmates and staff. This will be expensive and logistically challenging, but the cost and trouble are justified because the topic is of such great importance.
- Correctional systems should involve inmates and staff in the development of AIDS educational programs. This can be done by soliciting particular questions and concerns and using them as the basis of the training.
- AIDS training should be live, so that inmates have a chance to ask questions and receive answers from knowledgeable speakers.
- Live training should be supplemented with videotapes and/or written informational materials.
- All educational programs and materials should use simple non-technical language understandable to the intended audience.
- Credibility is absolutely critical to the success of AIDS training. Systems can build credibility by using knowledgeable and approachable trainers, ensuring that all training is factual and consistent, and by using peer trainers who are able to develop strong rapport with audiences.
- AIDS education should avoid extremes of alarmism and complacency. It should neither advocate unnecessary and inappropriate measures nor encourage a false sense of security in any group. Rather, training should emphasize that *everyone* must avoid certain well-defined behaviors and exposures.
- AIDS training should be keyed to the specific concerns of a correctional audience. Strictly generic materials are insufficient.
- AIDS training content should focus on specific risks and specific practical precautionary measures for inmates and staff. Inmate training should stress abstinence from drug use and sexual activity. However, as a realistic response, many correctional systems also include "safer sex" guidelines and information on cleaning needles.
- All AIDS training and materials distribution should be documented in case of future lawsuits. This may enable systems to counter claims that insufficient training on risks and precautions was provided.
- AIDS training and education should be periodically evaluated so it can be updated and improved.

HIV Antibody Screening and Testing

Chapter Four discusses the major applications of HIV antibody testing in the correctional setting and the perceived advantages and disadvantages of the range of testing options open to correctional administrators. The most controversial testing application is mass screening of inmates in the absence of clinical indications. In the correctional setting, we define mass screening as the mandatory testing of all inmates or all new inmates.

There are a variety of possible applications for the antibody test besides mandatory mass screening. These include screening inmates with discernible histories of high-risk behavior testing in response to incidents in which transmission of the virus may have occurred, voluntary testing, testing on request, and testing in support of epidemiological studies. Finally, correctional systems rarely become involved in staff testing, except perhaps in response to possible transmission incidents.

Twelve state correctional systems have implemented or are planning to implement mass screening programs for inmates; no city or county systems have instituted or planned such programs for inmates. The Federal Bureau of Prisons tests all inmates on release and a 10 percent random sample of incoming inmates. However, almost all of the jurisdictions responding to the survey do employ testing for more limited purposes, such as when clinically indicated or when requested.

The issue of mass screening for antibodies to HIV in correctional institutions has sparked an intense debate, involving the following major questions:

- Are HIV Antibody Tests Reliable and Accurate?

  Proponents of mass screening argue that the available tests are highly reliable and accurate, with very few false positive and negative results.

  Opponents point out that there continue to be serious concerns about the number of false positives and false negatives.

- Can Mass Screening Prevent Transmission of HIV?

  Proponents argue that mass screening facilitates policies that will reduce transmission of HIV in correctional facilities.

  Opponents reply that it is better to focus prevention and classification strategies on inmates likely to be predatory or otherwise prone to high-risk behaviors, rather than trying to identify all infected inmates, many of whom may not pose behavioral problems.

- Will Mass Screening Improve Medical Monitoring and Care?

  Proponents suggest that identifying seropositives will facilitate timely medical management.

  Opponents argue that it is unfair to subject seropositives to inevitable stigma when there is no cure available, and that there are reasonable alternatives for the proactive identification of inmates at high risk for HIV infection.

- Is it Possible to Maintain the Confidentiality of Antibody Test Results in Correctional Facilities and How Does Disclosure of Results Affect Seropositive Inmates?

  Proponents of mass screening argue that confidentiality can be maintained.

  Opponents argue that confidentiality of such sensitive information is impossible to maintain in a correctional setting, and that disclosure of test results will inevitably lead to ostracism and serious discrimination.

- What are the Legal Implications of Mass Screening?

  Proponents argue that mass screening is legal and proper and that failure to identify potentially infectious inmates could raise serious liability problems for the correctional system.

  Opponents argue that mass screening is illegal in many jurisdictions and that any legal liabilities could be effectively addressed by better procedures for the prevention of sexual victimization.

- How Costly are Mass Screening Programs?

  Proponents argue that systems can implement screening quite economically.

  Opponents respond that costs may be very high, particularly when periodic follow-up testing of seronegatives and separate housing and programming for seropositives are considered.

- Will Mass Screening Support or Undermine the Effects of Education and Prevention Programs?

  Proponents of mass screening argue that potentially infectious inmates must be identified so that they may be targetted in education and prevention programs.

  Critics respond that such differential education and prevention programs needlessly stigmatize one group of inmates while perhaps lulling the others into a false sense of security. In fact, everyone should receive the same educational messages regarding high-risk behaviors.

- Will Mass Screening Allay or Inflame the Fears of Inmates, Staff, and the Public?

  Proponents suggest that mass screening could help to calm the concerns of inmates, staff, and the public.

  Critics contend that mass screening will needlessly inflame fears, particularly if seropositivity rates are found to be high.

- Is Mass Screening the Best Way to Assess the Extent of the AIDS Problem in an Inmate Population?

  Proponents argue that mass screening is the best way to determine the scope of the problem.

  Critics reply that the same information can be obtained from blind epidemiological studies.

- Should Correctional Systems be Taking Steps Not Taken in Society at Large?

  Proponents contend that presumed high rates of infection with and transmission of HIV in correctional facilities justify the mandatory mass screening of inmates.

  Critics respond that infection rates are low in many correctional populations and that available evidence also suggests low rates of HIV transmission among inmates.

Decisions about whether or not to institute mass screening should be based on careful consideration of these issues, rather than on the political pressure that has arisen on the subject.

Medical, Psycho-Social, and Correctional Management Issues

Chapter Five discusses four key areas of policy: medical management, counseling and psycho-social services, housing policy, and precautionary measures. Major findings and recommendations include the following:

- Quality medical care should be provided to all inmates infected with HIV. AIDS patients, in particular, need humane and supportive care and access to AZT and other therapeutic drugs as indicated.
- Emphasis should be placed on proactive identification and monitoring of inmates at high risk of HIV infection and AIDS. This should be done through comprehensive intake screening and regular follow-up.
- Comprehensive psycho-social services and pre-release planning are also essential for inmates with asymptomatic HIV infection, ARC, and AIDS. This must include pre- and post-test counseling and guidance on responsible behavior to avoid the infection of others.
- Costs of care for inmates with AIDS are very high, but may be reduced by eliminating unnecessary hospitalizations. At the same time, such reductions may be counterbalanced by the high cost of AZT, which is becoming a major correctional cost concern.
- Most correctional systems still segregate or hospitalize inmates with AIDS, but there has been a noticeable trend away from blanket segregation of asymptomatic seropositives and inmates with ARC. Systems should consider case-by-case housing and programming decisions based on the inmate's medical situation, need for protection, and likelihood of engaging in behaviors that may place others at risk.
- Correctional systems should establish "universal precautions" for blood and body fluids. That is, unprotected contact with the blood or body fluids of *everyone* should be avoided.
- Reasonable and consistent precautionary procedures should be established to help staff safely deal with a variety of situations, including altercations, blood spills, searches, CPR, and biting incidents.
- Correctional systems should not adopt precautionary measures beyond those recommended by CDC for clinical staff.
- Several correctional systems currently make condoms available to inmates in institutions, emphasizing that this is not to condone prohibited behavior but only to recognize that it occurs and to provide for reasonable risk reduction. Other correctional systems may wish to assess this experience in reaching their own policy decisions.

Confidentiality, Legal, and Labor Relation Issues

Chapter Six discusses the difficult issues surrounding confidentiality and disclosure of AIDS-related medical information in the correctional setting, as well as the key legal and legislative developments regarding AIDS in corrections. Among the findings are the following:

- Realistically, it is difficult to maintain the confidentiality of sensitive AIDS-related information in prisons and jails; however, because of the potentially serious consequences of unauthorized disclosure, it is essential that correctional authorities make the strongest possible efforts to preserve confidentiality. In many jurisdictions, confidentiality of AIDS-related information is specifically required by law.
- No disclosures should be made except where clearly required by medical, safety, or institutional security considerations.

- Policies should be adopted and enforced which specify clearly who is permitted to receive information, what information is to be disclosed, and under what circumstances. Vague policies permitting disclosure to those with a "need to know" are insufficient.

- In conformance with recent CDC guidelines, correctional medical staff should strongly counsel persons infected with HIV to inform their sex partners; if an individual refuses to notify his or her partners, then correctional medical staff should carry out the notification in a confidential manner.

- Since 1985, there has been a great increase in litigation related to AIDS in correctional facilities. This has focused on the following areas, among others:

  1. challenges to segregation and conditions of confinement;
  2. quality of medical care;
  3. attempts to mandate mass screening of inmates for antibodies to HIV and segregation of seropositives;
  4. confidentiality and disclosure of medical information.

- Most disposed cases on these issues have been decided in favor of correctional systems, on the grounds that their policies were in furtherance of legitimate medical, correctional management, or institutional security objectives. However, many cases remain pending.

- The legality of mandatory testing in response to potential transmission incidents remains unclear; it is clearly prohibited in many jurisdictions under current law, but many judges believe that they can issue court orders to require such testing in certain instances.

- Many correctional systems are worried about their potential liability for HIV infections which occur among inmates while incarcerated and among staff while on the job. There are serious difficulties in linking infection with a particular episode; however, correctional systems can probably eliminate any potential liability, and maximize safety in their institutions, by preventing inmates from being victimized and providing all inmates and staff with clear and complete training on how to avoid becoming infected with HIV.

- The most important AIDS-related labor relations issue is whether correctional employees should or may be excused from their duties out of fear of AIDS. Correctional and other law enforcement agencies have been clear on this issue: such refusals are unjustified and will result in disciplinary action.

- As yet, there have been no AIDS-related employment cases brought by correctional staff under federal rehabilitation laws. However, correctional agencies should keep abreast of the caselaw which strongly suggests that action against employees with AIDS or asymptomatic HIV infection on the basis of their medical condition is impermissible, unless directly tied to their ability to perform the job.

- There has been a great deal of legislative activity regarding AIDS in corrections during the last year. Most legislative proposals have called for mandatory HIV antibody screening of inmates and segregation of seropositives. While several more limited testing bills have passed, none of the mandatory mass screening proposals have become law.

Part One

The Problem of AIDS

Chapter 1: Essential Medical Information

Acquired Immunodeficiency Syndrome (AIDS) is a serious communicable disease that undermines the human body's immune system. It makes the individual susceptible to a range of "opportunistic" infections, malignancies, and other diseases which would not generally be life-threatening to persons with normally functioning immune systems. AIDS also directly causes dementia and other disorders of the central nervous system. While the overall incidence of AIDS in the American population is still relatively small (8.6 cases per 100,000 population in 1987[1]), the disease nonetheless represents a very serious public health problem. This is primarily because of the high mortality rate, the continued lack of a vaccine or cure for the disease, the potentially very large number of infected (and infectious) individuals, the uncertain but often prolonged incubation period, and the uncertainty as to what proportion of infected persons will develop AIDS-related symptoms or the end-stage disease itself.

AIDS was first recognized in the United States in 1981, although it may actually have appeared in this country as early as 1969. The disease was identified through studies of several groups of previously healthy gay men who developed an unusual form of pneumonia *Pneumocystis carinii* pneumonia) and a rare form of cancer (Kaposi's sarcoma). In the absence of other causes, the appearance of these diseases gave evidence of an underlying immunodeficiency in the patients.

AIDS has a very poor prognosis: 85 percent of patients whose cases were reported at least four years ago have died. Although periods of survival vary considerably, no one has ever recovered from the disease. Research is proceeding on many fronts and has provided some promising results, but there is still no effective vaccine or cure for AIDS. The statements that have been made by scientists and researchers since the beginning of the epidemic remain just as true today: "our only weapons against AIDS are education and behavioral change." This prescription is equally applicable to the correctional setting and the society at large. Indeed, this report will stress that education and training must be the cornerstone of the correctional response to AIDS.

The Cause of AIDS: Human Immunodeficiency Virus

In 1983 and 1984, scientists at the Institute Pasteur in Paris and the National Institutes of Health identified and isolated the cause of AIDS: a virus first called lymphadenopathy-associated virus (LAV), or Human T-Cell lymphotropic virus Type III (HTLV-III), and now generally known as Human Immunodeficiency Virus (HIV). HIV is a "retrovirus," a type of infectious agent that had previously been identified as causing many animal diseases. The designation "retrovirus" derives from the backward, or "retro-", flow of genetic information from RNA to DNA, which reverses the normal flow of genetic messages.[2]

While it is now universally believed that HIV is an indispensable requirement for the development of AIDS, there is still a great deal of research being done on "co-factors" that may render some individuals more susceptible to infection and HIV-related illness than others. Possible cofactors include genetic factors, other infections such as hepatitis-B, alcohol or drug use, and malnutrition.[3]

HIV infects and destroys certain white blood cells (T4 cells), thereby undermining that part of the body's immune system which normally combats infections and malignancies. One can be infected with HIV for years, possibly even indefinitely, without ever developing symptoms. However, asymptomatic (as well as symptomatic) persons can transmit the infection.

HIV Antibody Tests and Their Applications

In early 1985, a commercial test for antibodies to HIV became available. The basic test is an enzyme-linked immunosorbent assay (ELISA or EIA), a method which is used for other purposes besides detection of antibodies to HIV. (However, for convenience, we refer hereafter to the basic HIV antibody test as the ELISA test.) It is not a test for AIDS, nor does it even detect the presence of the virus itself—only the presence of antibodies to the virus. Antibodies are evidence, present in the blood, of the immune system's attempt to fight off an infection.

Actual culturing of the virus (i.e., growing the virus from a specimen of body fluid or tissue) is very difficult and expensive and is currently performed in only a few research laboratories. Other blood tests for the virus (e.g., T-cell tests) are also difficult and expensive. However, at this writing, new techniques for detecting HIV antigen (part of the virus itself, as opposed to antibodies to the virus) are undergoing clinical trials and may be available quite soon. A principal advantage of the antigen test is that it will be positive immediately upon infection, whereas the antibody tests will be falsely negative during the period between infection and appearance of antibodies. This period is generally thought to be between three and twelve weeks, although some recent data indicate that the lag-time may sometimes be significantly longer.[4]

The ELISA test was developed to screen the blood supply, and it has been very effective for that purpose. The nation's blood supply is now considered safe. Several recent reports indicate that a small number of infected units of blood may have slipped through undetected, because the donor was only recently infected and antibodies had not had time to appear by the time the blood was donated. However, the Centers for Disease Control (CDC) estimates that only about 100 transfusion-associated infections will occur annually out of a total of sixteen million units transfused. The National Academy of Sciences report on AIDS estimates the risk of transfusion-associated infection at fewer than one in 34,000 recipients of packed red blood cells.[5]

HIV antibody tests are now being used to screen people rather than blood, as well as to complement diagnostic procedures. The first widely publicized application of the HIV antibody test to screen people was the Defense Department's screening of all recruit applicants for the armed forces. The government has also instituted screening of all active-duty and reserve military personnel. In the Spring of 1987, the President recommended that all prison inmates and potential immigrants be screened as well. Soon after, the Attorney General ordered the Federal Bureau of Prisons to begin testing all new inmates and all inmates about to be released. A number of other correctional systems have followed suit. However, as discussed in Chapter Four, there continues to be substantial controversy surrounding the accuracy of the tests and their application to screening and diagnosis of individuals.

Screening of donated blood and blood products is based on a single ELISA test. Units of blood testing positive are discarded. However, when people are being tested, careful confirmation of results is necessary. The ELISA test may produce a significant number of false positives, particularly in populations where the true prevalence of infection is low. Therefore, the CDC strongly recommends that initially positive specimens be subjected to a second ELISA test and that a more accurate test—typically the Western Blot test—be used to confirm the ELISA result.[6] As will be discussed in Chapter Four, however, there continue to be concerns regarding the number of false positives even when Western Blot confirmation is performed.

A properly confirmed result on the HIV antibody test means that an individual was infected at some time in the past. However, the test cannot pinpoint the date of infection. Notably, a negative result on the HIV antibody test means only that the individual had not been infected with HIV (or had been infected but had not developed antibodies) as of the time the blood sample was taken. It says nothing about the likelihood of future infection or susceptibility to infection. Indeed, this is one of the key messages to present in post-test counseling of seronegative persons. Individuals who have engaged, and are continuing to engage, in high-risk behaviors should be told that their negative result represents "pure luck" and that the only ways to reduce their likelihood of becoming infected in the future are to discontinue these behaviors immediately or, at least, to begin taking appropriate precautionary measures.[7]

Definitions

AIDS is not a single disease: indeed, there is a spectrum of possible reactions to HIV, from no symptoms to "end-stage" AIDS. Terms have been given to some basic degrees of reaction along this spectrum: asymptomatic HIV infection; AIDS-Related Complex (ARC); and end-stage AIDS. However, there are variations in the definitions of these terms and, in fact, some researchers and physicians have defined alternative points along the spectrum of illness. Moreover, according to the National Academy of Sciences, the points along the spectrum "cannot be considered simply as stages of an orderly progression in the spectrum of HIV infection."[8] For those individuals who do pass through these conditions sequentially, there is no standard rate or pace of progression. Some patients remain asymptomatic for long periods—perhaps indefinitely—while others quickly develop end-stage AIDS and die. What causes these wide variations in clinical history is not known. However, a basic understanding of the complexities and variations of the definitions is a prerequisite for understanding the epidemiology of AIDS. The following categories are the most important and widely used.

AIDS ("end-stage")

HIV infection has no independent symptoms except a form of dementia (HIV encephalopathy) similar to that found in Alzheimer's Disease. Otherwise an AIDS diagnosis is based on the presence of "indicator diseases" found in individuals whose immune systems are compromised, but not generally seen in individuals with normal immune systems. The two most common indicator diseases continue to be *Pneumocystis carinii* pneumonia and Kaposi's sarcoma. The CDC "surveillance definition" of AIDS (i.e., the definition used for enumeration and epidemiological analysis of AIDS cases in the United States) has been revised several times since first being issued in 1981.[9] The most recent CDC definition, issued in August 1987, is included in Appendix B. It makes three basic changes in the diagnosis of AIDS. First, it adds as AIDS indicator diseases some "progressive, seriously disabling, and even fatal conditions" that are neither infections nor cancers and were thus omitted from previous definitions. These conditions include AIDS dementia and HIV "wasting syndrome," which is characterized by significant, involuntary weight loss plus either 1) chronic diarrhea *or* 2) chronic weakness *and* persistent fever. These symptoms of HIV wasting syndrome must be unexplainable by reference to any other illnesses. Patients definitively diagnosed (i.e., with laboratory confirmation) with any one from this expanded list of indicator diseases and with laboratory evidence of HIV infection (typically, a properly confirmed positive antibody test sequence) are to be considered AIDS cases. In particular, the inclusion of HIV wasting syndrome as an indicator disease for AIDS may move a significant number of patients previously considered to display AIDS-Related Complex (ARC) into the category of end-stage AIDS.

Second, according to the new definition, the presence of any one of this expanded list of definitively diagnosed indicator diseases in a patient with laboratory evidence of HIV infection now indicates a diagnosis of AIDS, *regardless* of the presence of other causes of immunodeficiency. Previously, such other causes of immunodeficiency disqualified a case from an AIDS diagnosis.

Third, the new definition specifies that patients in which certain indicator diseases (e.g., *Pneumocystis carinii* pneumonia and Kaposi's sarcoma) have been "presumptively" diagnosed (i.e., without the laboratory confirmation previously required) should be diagnosed as AIDS cases in the presence of laboratory evidence of HIV infection.

In short, these changes have significantly expanded the surveillance definition of AIDS. Ultimately, they are expected to add 10-20 percent to the total number of AIDS cases. This definitional expansion became effective September 1, 1987. As of December 28, 1987 it had resulted in 2,700 additional cases, 13 percent of the AIDS cases reported to CDC since January 1, 1987.[10]

AIDS-Related Complex (ARC)

The designation "AIDS-Related Complex" (ARC) has never been officially recognized, but is still widely used. A diagnosis of ARC is based on the presence of a combination of conditions, often quite mild, that together give evidence of infection with the AIDS virus. The symptoms of ARC may subside, but the individual remains infected. The most commonly used definition of ARC is from the National Institutes of Health: any two from a long list of symptoms including swollen lymph nodes, weight loss, and night sweats, plus any two from a list of laboratory abnormalities, including blood test results showing depressed helper T-cells and depressed helper/suppressor ratio. (The complete NIH definition is also included in Appendix B.) As discussed above, the new CDC surveillance definition of AIDS effectively incorporates some patients previously considered to have ARC. However, many other individuals with symptoms of HIV infection (such as those with night sweats or persistent generalized lymphademopathy [PGL] — swollen lymph nodes) still do not qualify as AIDS cases and thus should be considered to have ARC.

Asymptomatic HIV Infection

Many individuals (perhaps as many as 1.5 million in the United States) are infected with HIV but have not developed any symptoms of disease. Asymptomatic infection is identified by antibody testing. The CDC recommends that all confirmed seropositive individuals (i.e., those with a confirmed positive HIV antibody test sequence) be considered infected, although, strictly speaking, the test results only show that the individual has been infected with the AIDS virus at some time in the past.

Seropositive individuals may never develop any symptoms, let alone develop end-stage AIDS. However, they are capable of transmitting the infection to others, even if they never develop symptoms themselves.

The Relationships Among Exposure, Infection, HIV Seropositivity, and Development of ARC or AIDS

Figure 1.1 summarizes the meanings of exposure, infection, seropositivity, ARC, and AIDS and the relationships among these stages. "Exposure" to HIV means that the individual has had contact with the

Figure 1.1

RELATIONSHIPS AMONG EXPOSURE, INFECTION, HIV SEROPOSITIVITY, ARC, AND AIDS

Stage	Meaning	Relationship to Previous Stage(s)
Exposure	Individual has contact with HIV in a way that makes transmission possible (e.g., sexual contact or needle-sharing activity)	–
Infection	Individual is infected with HIV. Infection is assumed to be permanent.	Unknown, although multiple exposures probably increase the risk of infection.
Seropositivity	Individual has antibodies to HIV, meaning that infection has occurred at some time in the past. Antibody tests cannot pinpoint date of infection. It usually takes 3-12 weeks from the time of infection for the antibodies to appear, although lag-times significantly longer have been reported.	CDC considers double ELISA test confirmed with a Western Blot to be an accurate indicator of infection status; however, there continues to be concern about false positives, particularly in populations with a low prevalence of infection (See Chapter Four).
ARC	Presence of a combination of conditions together giving evidence of symptomatic infection with HIV. (Note: New CDC definition of AIDS incorporates many individuals previously classified as ARC patients)	National Academy of Sciences estimates that 90% of seropositive individuals show some immunodeficiency within 5 years.
AIDS	Illness characterized by one or more "indicator diseases" listed by CDC.	It is generally believed that at least one-half of seropositive individuals and individuals with ARC will develop AIDS. However, all estimates are uncertain due to the lengthy incubation period.

virus in a way that would make it possible for him or her to become infected (e.g., sexual contact or needle-sharing activity). It is not known exactly what fraction of exposed persons will become infected and remain infected. However, research on a cohort of sexually active homosexual males in San Francisco reveals very high rates of seroconversion (i.e., becoming HIV seropositive over time), indicating that multiple exposure increases the risk of infection. A representative sample of the cohort was 4 percent seropositive when their blood samples (collected in 1978) were first tested. By 1985, the seropositive rate in the sample had increased to an astounding 73 percent. Seroconversion in homosexuals and heterosexuals has been repeatedly linked to number of sexual partners.[11]

HIV seropositivity means that an individual was infected at some time in the past, although the antibody tests cannot pinpoint the date of infection. Thus, the view commonly presented in articles regarding AIDS (as well as in some correctional departments' educational materials and policy statements) that HIV seropositivity merely indicates possible "exposure" to the virus is considered by many physicians and epidemiologists to be a serious misunderstanding. Indeed, CDC's current position is that, for the purposes of counseling and making public health recommendations, any seropositive person should be considered infected and potentially infectious. The long—possibly indefinite—incubation period of AIDS makes seropositivity a very serious problem because it is never possible for a seropositive individual to know for certain that he or she is free from risk of becoming ill or infecting others.

It is now generally believed that a majority of seropositive persons will develop ARC and/or AIDS. Estimates have continued to increase with the passage of more time to track infected individuals in cohort studies. The National Academy of Sciences estimates that 25-50 percent of HIV seropositives will develop AIDS within five-ten years of infection. The report also notes that more than 90 percent of seropositive individuals show some immune system deficiency within five years of seroconversion.[12] Many physicians now believe that all individuals infected with HIV will ultimately become ill unless an effective therapeutic intervention is introduced.

Research findings are beginning to suggest the quantitative relationships among seropositivity, infection, and the development of illness. However, among the most puzzling questions about AIDS remain the determinants of actual infection among those persons exposed to the virus and the determinants of developing symptoms or becoming ill among those persons who are infected. Intensive research continues to be devoted to "co-factors" of infection and the mechanics of infection. Possible co-factors under investigation include genetic characteristics, environmental characteristics, malnutrition, history of sexually-transmitted diseases and/or drug and alcohol use which may weaken the immune system, and the use of nitrate inhalants ("poppers").[13] Mechanical issues include the inoculum size (amount of virus) and the number of doses required to transmit infection. Although the minimum dose of virus necessary to cause infection is still unknown, there appears to be a developing consensus that a large inoculum given intravenously (such as in a blood transfusion) poses an extremely high risk, while a single small inoculum given parenterally (i.e., through the skin, as in an accidental needlestick) poses a very low risk of infection. At the same time, repeated exposures to small doses (through repeated sexual contact or sharing of contaminated needles) ultimately present a grave risk of infection.[14] Thus, the probability of infection is based on the interaction of a number of variables, including:

- inoculum size per exposure;
- virulence of the viral strain to which exposed (there may be different strains of HIV with differing levels of virulence);
- number of exposures; and
- co-factors of infection present.

On the other hand, some still subscribe to what Dr. Charles Rabkin, a New York City Health Department epidemiologist, terms "the Russian-roulette theory": that development of HIV infection is almost purely a matter of chance; a person who engages in sexual intercourse with an infected person or shares a contaminated needle has a small chance, each time, of becoming infected.[15] Under this theory, of course, the cumulative risk of infection increases as the number of potential exposures increases.

While these observations refer specifically to the relationship between exposure and infection, similar hypotheses have been advanced regarding the relationship between infection and development of ARC or AIDS. In particular, it has been suggested that continued exposures subsequent to initial infection may increase the chances that symptoms will develop.

Incubation Period of AIDS

As more information is gathered and analyzed on the natural history of AIDS, the more it appears that in most cases the progression from asymptomatic infection to end-stage AIDS occurs very slowly. Although in some cases the progress to AIDS is very rapid, the incubation period is usually two and one-half to five years or more. Indeed, some researchers believe that there may be no real maximum incubation period—that is, an infected person may develop symptoms at any time during his or her life. Because of the painful uncertainties and anxieties involved, this is one of the most troubling aspects of the disease.

The often lengthy incubation period of the disease also poses problems for epidemiologic analysis. The patterns of actual disease appearing now reflect the patterns of infection that were occurring several years ago; they do not necessarily reflect what the patterns of the disease will be several years from now.

Survival with AIDS

AIDS is a fatal disease. Overall, 57 percent of persons diagnosed with AIDS have died. However, among cases diagnosed in 1981, the fatality rate is over 90 percent, and over 80 percent among cases diagnosed in 1984.[16] A recent study of almost 6,000 New York City AIDS cases diagnosed before 1986 found a median length of survival of just under one year from time of diagnosis and a 15 percent cumulative probability of surviving five years. However, survival, particularly in the first year after diagnosis, varied considerably according to primary indicator disease, demographic characteristics, and transmission category. The median survival for patients with Kaposi's sarcoma only was 750 days, while for those with *Pneumocystis carinii* pneumonia it was only 318 days. (Earlier diagnosis and improving application of existing clinical regimens, however, now appear to be increasing at least the short-term survival among patients with *Pneumocystis* *carinii* pneumonia.)[17] Other factors in combination with indicator disease also influenced survival. For example, black female intravenous drug abusers with *Pneumocystis carinii* pneumonia had a much shorter mean survival period than white gay males 30-34 years old presenting with Kaposi's sarcoma only, and no history of intravenous drug use. Patients who were both homosexual and intravenous drug users had poorer prognoses than those with only one of these risk factors.

Transmission of HIV Infection

One of the most serious problems affecting the public response to AIDS has been the great amount of misinformation and unfounded rumor about how the infection is transmitted. There have been highly publicized cases of parents refusing to send their children to school with children who have AIDS or to permit their children to use swimming pools which had been used by persons with AIDS, and of office workers refusing to work with persons who have AIDS. Public opinion polls reveal continued widespread belief that HIV infection can be transmitted through casual contact in normal social settings. In the summer of 1987, the United States Public Health Service's Weekly National Health Interview Survey found that 47 percent of respondents believed HIV transmission was likely through shared utensils, 31 percent thought transmission was likely through public toilets, 25 percent believed that one could be infected through *donating* blood, and 21 percent thought they could be infected by co-workers in normal workplace interaction.[18] Inmates and staff of correctional institutions have not been exempt from such misinformed fears. This section summarizes medical knowledge on how HIV infection is and is not transmitted.

Known Means of Transmission: Sexual Contact, Inoculation of Blood, and Perinatal Events

There is extremely reliable information on the means of transmission of HIV infection and AIDS. The major routes of transmission have been firmly established since early in the epidemic. Skeptics often complain that "we can't really be sure" about how the virus is transmitted, since "new information comes out every day." It is true that there is a steady stream of new information on many aspects of AIDS – for example, on vaccines and therapeutic drugs, the proportion of infected persons who will develop symptoms, and possible co-factors of infection and disease. Information on these subjects has, and will continue, to change. However, there has been *no new information* on means of transmission since 1981 or 1982. The primary means of transmission, as shown in Figure 1.2, are the following:

1. sexual intercourse;
2. infusion or inoculation of blood; and
3. perinatal events.[19]

With the exception of one case apparently transmitted to an infant through breast milk and a small number of cases lost to followup for various reasons, all known cases of AIDS and HIV infection are attributed to one of the three means of transmission listed above. Figure 1.3 presents more detailed information on the precise types of contact included under each of these three means of transmission and the relative risk of infection through such contacts.

Almost 50,000 cases into the epidemic, it is absolutely clear that the overwhelming majority are attributable to contact with blood, semen, or vaginal secretions in sexual relations or with blood in needle-sharing activities. It is inconceivable at this point that major new means of transmission remain to be discovered.

It is particularly important to emphasize that HIV is difficult to transmit and is not transmitted by any form of casual contact. Moreover, infection is highly unlikely based on a single exposure involving a small dose of virus. The virus is very fragile when outside the human body. It is susceptible to heat, to many com-

Figure 1.2

KNOWN ROUTES OF HIV TRANSMISSION

Sexual Intercourse

Homosexual, between men
Heterosexual, from men to women and women to men

Inoculation of blood

Transfusion of blood and blood products
Needle sharing among intravenous drug users
Needle stick, open wound, and mucous-membrane exposure
Injection with unsterilized needle

Perinatal

Intrauterine (before delivery)
Peripartum (during delivery)

SOURCE: Adapted from Friedland, "Transmission of HIV," p. 1126

Figure 1.3

RISK OF INFECTION THROUGH SPECIFIC MEANS OF HIV TRANSMISSION

Body Fluids Shown to Have Transmitted HIV	When Coming Into Contact With. . .	Through. . . (Activity or Exposure)	Frequency of Transmission Through This Means (Data on AIDS cases are as of December 28, 1987)
Semen	Blood	Sexual intercourse: Male to Male (anal)	31,825 - 35,514 (65 - 73%) of adult AIDS cases[a]
		or Male to Female (vaginal or anal)	864 (2%) of adult AIDS cases[b]
Blood	Blood	Sharing of needles and "works" by IV drug abusers	8,411 - 12,100 (17 - 25%) of adult AIDS cases[a]
		Transfusion	1,221 (2%) of all AIDS cases
		Blood preparations for hemophiliacs	524 (1%) of all AIDS cases
		Accidental needlestick	0 cases of AIDS; 4 cases of HIV infection among 887 health care workers with needlestick exposure (5 studies): 0.5%[c]; 1 case in a dentist with history of needlesticks.[d]
		Medical injection with unsterile needles	0 cases of AIDS or HIV infection in U.S.; but probably a major factor in Third World countries
		Exposure of open wound/ broken skin	0 cases of AIDS; 5 cases of HIV infection among health-care workers, all of whom failed to follow CDC-recommended precautions; 0 cases of infection among 435 health-care workers with non-needlestick exposures (3 studies)[e]
		Perinatal transmission (mother to fetus or infant)	566 (1%) of all AIDS cases

mon household disinfectants and detergents, and to hot water and soap.

HIV infection is often compared to Hepatitis-B infection in that both are transmitted by exposure to contaminated blood and other body fluids, primarily during sexual and needlesharing activities and intravenous drug use. However, Hepatitis-B is transmitted more efficiently than HIV infection.[20] Therefore, infection control measures (such as precautions regarding contact with blood and other body fluids) designed to prevent transmission of Hepatitis-B are more than sufficient. Indeed, CDC recommends that these precautions be used to prevent HIV infection. More extreme measures than those recommended for Hepatitis-B are unnecessary and inappropriate for preventing transmission of HIV infection.

Sexual Transmission

It is clear that HIV can be transmitted through male-to-male homosexual contact and through heterosexual contact, both male-to-female and female-to-male. As with any sexually-transmitted disease, the risk of infection with HIV increases as the number of potential exposures increases. Thus, those who are extremely active sexually, with numerous partners and especially with partners not previously well-known to them, are almost certainly at higher risk. This applies to heterosexuals as well as to homosexuals and bisexuals. There is strong evidence that anal intercourse (especially for the receptive, as opposed to the insertive, partner) and other practices that may involve trauma or bleeding are especially risky. However, the risk of transmission involved in vaginal intercourse and other

Figure 1.3

RISK OF INFECTION THROUGH SPECIFIC MEANS OF HIV TRANSMISSION

(continued)

Body Fluids Shown to Have Transmitted HIV	When Coming Into Contact With. . .	Through. . . (Activity or Exposure)	Frequency of Transmission Through This Means (Data on AIDS cases are as of December 28, 1987)
Blood	Mucous Membrane (eye, mouth, nose)	Accidental splashes	1 case of HIV infection in a health-care worker not following CDC-recommended precautions; 0 cases of infection among 435 health-care workers with non-needlestick exposures (3 studies)[e]
Vaginal Secretions	Blood	Vaginal intercourse (female-to-male)	243 (0.5 %) of adult AIDS cases [f]
Breast Milk	Mucous Membrane	Ingestion	1 case of HIV infection in Australia[g]
Body Fluids Found to Contain HIV but not implicated in transmission: Saliva Tears Urine			
Body Fluids/ Substances not found to contain HIV: Feces Vomitus Perspiration			

forms of sexual activity should not be minimized. CDC emphasizes that any unprotected sexual activity involving exchange of body fluids should be avoided when either partner is known or suspected to be infected. Condoms are considered generally effective, but not absolutely foolproof, in preventing transmission.

Disagreement continues on the current and projected scale of heterosexual transmission of HIV. It is true that the percentage of AIDS cases attributed to heterosexual contact remains small – about 4 percent. However, this percentage has increased from 2 percent in 1984, and the *number* of heterosexual cases has increased more rapidly than the numbers in other transmission categories.

Important evidence of heterosexual transmission comes from studies of heterosexual couples and military recruits in the United States and also from the African experience. Studies of stable, long-term monogamous heterosexual couples reveal that 7 to 68 percent of the steady sexual partners of HIV-infected individuals themselves become infected within a few years.[21]

The sex distribution of African AIDS cases is nearly equal, in contrast to the male-dominated epidemiology seen in the United States. It should be noted, however, that African cultural factors might strongly inhibit the reporting of homosexual experiences, thus possibly exaggerating the apparent extent of heterosexual

Figure 1.3

RISK OF INFECTION THROUGH SPECIFIC MEANS OF HIV TRANSMISSION

(continued)

NOTES

[a] CDC, AIDS Weekly Surveillance Report, December 28, 1987. Range results from uncertainty as to the relative proportions of the cases in the category "Homosexual Male and IV Drug Abusers" attributable to homosexual contact and to needle sharing.

[b] An additional 194 AIDS cases were in women born in countries where heterosexual transmission is believed to play a major role.

[c] Friedland, G.H. and R.S. Klein, "Transmission of the Human Immunodeficiency Virus," *New England Journal of Medicine*, October 29, 1987; 317: 1125-1135; Hirsch, M.S., et al., "Risk of Nosocomial infection with HTLV-III," *New England Journal of Medicine* 1985; 312:1-4; Weiss, S.H., et al., "HTLV-III Infection Among Health-Care Workers: Association with Needlestick Injuries," *Journal of the American Medical Association*, 1985; 254:2089-2093; Henderson, D.K., et al., "Risk of Nosocomial Infection with HTLV-III/LAV in a Large Cohort of Intensively-Exposed Health-Care Workers," *Annals of Internal Medicine*, 1986; 104:644-647; Gerberding, J.L., et al., "Risk of Transmitting HIV, Hepatitis-B virus, and Cytomegalovirus to Health-Care Workers Exposed to Patients with AIDS and AIDS-Related Conditions," *Journal of Infectious Diseases*, July 1987; 156:1-8; McCray, E., et al., "The Cooperative Needlestick Surveillance Group: Occupational Risk of AIDS Among Health-Care Workers," *New England Journal of Medicine*, 1986; 314:1127-1132.

[d] CDC, AIDS Program, unpublished data.

[e] McCray, et al., "Occupational Risk of AIDS Among Health-Care Workers;" Henderson, et al., "Risk of Nosocomial Infection with HTLV-III/LAV;" Gerberding, et al., "Risk of Transmitting HIV;" CDC, "Update: HIV Infections in Health-Care Workers Exposed to Blood of Infected Patients," *MMWR*, May 22, 1987; 36:285-288

[f] An additional 663 AIDS cases were in men born in countries where heterosexual transmission is believed to play a major role.

[g] Ziegler, J.B., et al., "Post-natal Transmission of AIDS-Associated Retrovirus from Mother to Infant," *Lancet*, 1985; 1:896-898.

---

transmission. In any case, sexual activity seems likely to be the predominant means of transmission in Africa, since almost all African cases are in the sexually active age range. Non-sexual modes of transmission, such as the use of unsterile needles in medical practice and transfusion with infected blood, are quite common in some African countries. However, if they represented the predominant mode of transmission, they would presumably have produced many more cases than have been identified among persons in non-sexually-active age groups. African studies also suggest that prostitutes are often carriers of HIV.[22]

The prevalence of other sexually-transmitted diseases—particularly those involving genital lesions which might provide a route of entry for the virus—may also be an important factor in heterosexual transmission of HIV infection in Africa. These diseases are not as prevalent in the United States. In general, it is sometimes argued that many of the factors important in African heterosexual transmission are absent in the United States. However, studies of American military recruits clearly establish that heterosexual transmission is occurring in this country.

Studies of American military recruits discovered a male-to-female ratio among HIV seropositives of 2.7 to 1 nationally, and 1.2 to 1 in the six counties with the highest seropositivity rates in the population as a whole. The national average male-to-female ratio of *AIDS cases* is thirteen to one. The studies also identified numerous married couples in which both partners were seropositive.[23] The recruit data may exaggerate heterosexual transmission, since certain male risk groups—gay men and hemophiliacs—are deferred from military service, and some of the infection reported in women may really have resulted from IV drug use. Thus, the data must be interpreted very cautiously. However, they strongly suggest that heterosexual transmission may have already become established in the young adult population in certain areas of the country, even though this type of transmission is not yet that prominent in statistics on AIDS cases. This, in turn, serves to underline the key point that the past and current epidemiological profile of AIDS cases may not accurately predict the future course of the epidemic.

The six counties which reveal the highest overall infection rates, as well as the 1.2 to 1, virtually even, male-to-female ratio among HIV seropositive recruits are also those where HIV infection is strongly associated with intravenous drug abuse. This provides strong evidence for the link already noted by many observers between heterosexual transmission of HIV and intravenous drug abuse. A large percentage of the persons infected thus far through heterosexual contact are the sexual partners of intravenous drug users. Most of these are minority women from the New York City metropolitan area and South Florida. A smaller percentage are sexual partners of bisexual men. In short, most heterosexual transmission thus far appears to involve direct contact with a member of one of the currently predominant risk groups. Although it is unclear what the future holds, it appears that, at least at present, there is not a significant amount of "tertiary" heterosexual transmission—that is, resulting from contact between heterosexuals, neither of whom are in well-established risk groups—occurring in the United States. This is one of the major arguments advanced against the "break-out" of HIV infection into the non-intravenous-drug-using heterosexual population.[24] Even if this is true, however, heterosexual transmission must be of concern to correctional administrators—particularly with regard to pre-release education—because intravenous drug users are over-represented among inmate populations.

Another argument against the "breakout" of heterosexual transmission is the estimated low probability of transmission through a single sexual encounter.[25] If the probability that any potential heterosexual partner is infected is very low—as it probably is at present in the non-intravenous-drug using population—then the risk associated with casual heterosexual activity may be much lower than that associated with casual homosexual activity (where the probability that any potential partner is infected is presumably much higher).

Finally, those who believe that widespread heterosexual transmission in the United States is unlikely argue that HIV is much less efficiently transmitted from female-to-male than from male-to-female. In particular, anal intercourse is considered much more likely than vaginal intercourse to result in direct insertion of the virus into the bloodstream.[26] In addition, the fact that anal intercourse is more prevalent among homosexuals than among heterosexuals is also asserted in support of the prediction that homosexual transmission of HIV will continue to be far more important than heterosexual transmission.

While many researchers believe that female-to-male transmission is less efficient, they also emphasize that its existence has been clearly established and should not be discounted. Moreover, they argue, epidemiological as well as biological factors may be involved. Because of the long incubation period, most AIDS cases being reported now resulted from infections which occurred when the virus was concentrated among men. The fact that very few women were infected meant that there were far fewer chances for female-to-male transmission to occur. As the number of infected women increases, so will the probability of female-to-male transmission.[27]

In sum, heterosexual transmission is an extremely complex issue, and its future course in the United States is unclear. Nevertheless, it has been clearly established that heterosexual transmission occurs, and that it is currently most common in areas with large numbers of intravenous drug users, in minority groups, and in young adults.[28]

Inoculation of Blood

Currently, exposure to HIV-contaminated blood occurs almost exclusively through needle-sharing by intravenous drug abusers. This is a population of particular interest to correctional administrators, because it is over-represented among correctional inmates. There have been cases associated with blood transfusions and hemophiliacs' receipt of blood products. However, as already noted, the nation's supply of blood and blood products is now considered safe, as a result of universal ELISA screening of donated blood and heat treatment of Factor VIII preparations of blood products regularly given to hemophiliacs. Additionally, there have been a very small number of infections resulting from accidental needlesticks and other forms of blood-to-blood and blood-to-mucous membrane exposure.

Transmission Associated with Intravenous (IV) Drug Use.[29] HIV is transmitted among IV drug users primarily through the exchange of blood which takes place during sharing hypodermic needles, syringes, cotton (or other material used as a filter), and "cookers," or containers in which the drug is heated and/or dissolved. Blood of the previous user lodges most often in the tip of the hypodermic needle or in the syringe, but may also be found in other parts of the apparatus.

During injection, the user may draw his/her own blood into the syringe to mix with the dissolved drug and then inject the blood/drug mixture, a procedure known as "booting". This is done to make sure all traces of the drug are removed from the syringe efficiently. As a result, however, any blood from a prior user which remains in the syringe or in the tip of the needle is injected directly into subsequent users. Traditionally, any cleaning of the syringe or needle only involves rinsing them in water or blowing into them. Sterilization equipment is not readily available to users and speed of injection is often paramount in the minds of addicts. Addicts may also be fearful of damaging precious equipment through sterilization procedures such as boiling. Users who "skin pop" drugs may also share unsterile equipment. "Skin popping" is a technique, common to early stages of IV drug use, in which the needle is inserted under the skin or into muscle tissue rather than directly into a vein.

The spread of HIV among IV drug users has been consistently linked to two factors: frequency of drug injection and the use of "shooting galleries" or similar commercial operations. It has been shown that the more often one injects drugs, the more likely one is to borrow or rent injection equipment that contains contaminated blood, thus increasing the likelihood of infection. Shooting galleries rent drug injection equipment to multiple users. After one person uses the equipment, it is returned to the proprietor for rental to the next person. Studies have shown that 90 percent-100 percent of IV users report sharing needles and almost three-quarters frequent shooting galleries in areas where they flourish. Both needle sharing in general and patronage of shooting galleries in particular are most common among the most serious drug users, since increased frequency of injection predicts increased likelihood of both types of sharing.

Shooting galleries are typically found in cities with large concentrations of IV drug users and are located near the areas in which drugs are sold. Shooting galleries are particularly common in the New York City metropolitan area, and this is thought to help explain the extremely high prevalence of HIV infection among IV drug users (probably 60 percent) and the large number of IV drug-use-related AIDS cases in the region. In smaller cities, shooting galleries are not as prevalent, but "house works," which can serve the same function of rapid spread of the virus among IV drug users, are likely to be available. A dealer who is selling illicit drugs for injection will often keep a set of "house works," injection equipment that is lent to a purchaser so the drugs can be used immediately. These works are then returned to the dealer for lending to the next customer.

It should be noted that the patronage of shooting galleries or the use of house works are not the only opportunities for needle sharing among IV drug users. Sharing also often occurs as part of initiation into drug use and as part of important social behavior with other users. Even in areas where shooting galleries are not common, a large percentage of users report that they share injection equipment daily.

Initiation into drug injection is also often the occasion of needle sharing. New users are unlikely to purchase their own injection equipment at first. Intravenous injection or "skin popping" is often done with and by an associate or friend who is experienced in the technique and who supplies the equipment. Initiation is not likely to be a planned event, and even subsequent injection may not involve the user's purchase of his/her own equipment because steady use has usually not been established at this point.

Sharing "works" with a partner, friend, or lover on a regular basis is also a common part of the drug world. Those who share are often "running partners". They commit crimes together and buy and use drugs together. Sometimes, only one of the pair will carry "works" and share it with the other, both as a convenience and a token of friendship. Injecting together may also be a way of splitting an amount of drugs or a mutual protection mechanism—partners watch out for signs of overdose. Sharing equipment in this fashion is an important social bond in the addict world, and refusal to share may be seen as a serious sign of mistrust or disloyalty among partners. Some sharing may also simply be a response to a scarcity of needles. Users not necessarily as close as those described above may also share simply out of convenience.

Transmission Through Accidental Needlesticks. Accidental needlesticks and punctures involving instruments contaminated with HIV-infected blood bear some similarity to needle sharing among IV drug abusers. However, there are critical differences which make the risk associated with these accidental injuries much lower than the risk involved in purposeful needle sharing activity. As discussed above, when intravenous drug abusers share needles, a small amount of the user's blood is often drawn into the syringe where it can mix with the remnants of blood of previous users similarly drawn. This blood, together with the drug, is then injected directly into the user's bloodstream.

In an accidental needlestick or puncture, by contrast, the risk is limited to the possibility that any contaminated blood which is present on the needle or instrument may come into contact with the blood of the person suffering the wound. In addition, addicted IV drug users who share needles are likely to experience multiple exposures which greatly increases their risk of infection over those who experience one isolated exposure.

As a result of these differences, the rate of HIV transmission is much higher in needle sharing by IV drug users than in accidental needlesticks. Researchers at the Centers for Disease Control and elsewhere have been gathering data on needlestick exposures to the AIDS virus for several years. Data from at least five U.S. studies suggest that the risk of HIV infection due to accidental needlestick or puncture wounds is extremely small. Of 887 health care workers experiencing needlesticks with needles known to have been previously used on HIV-infected patients, only four (0.5%) themselves became infected as a result of these exposures.[30] Additionally, of hundreds of dental workers—many of whom cared for persons with AIDS—studied, only one became infected as a result of these contacts. This individual had a history of cuts and needlesticks.

Transmission Through Open Wound or Mucous Membrane Exposures. The risk associated with open-wound and mucous-membrane (e.g., eyes, nose, mouth) exposures to HIV-contaminated blood is even lower than the risk associated with needlesticks. In three studies totaling 435 health-care workers with open-wound or mucous-membrane exposure to the blood of known HIV-infected patients, none became infected as a result of these exposures. Nevertheless, CDC has consistently stated that infection through such exposures was possible.[31]

Recent reports of five HIV infections (independent of the above-cited studies) apparently associated with non-needlestick exposures have increased concern among many occupational groups, including personnel in corrections and law enforcement agencies. Two persons providing nursing care to AIDS patients became infected following extensive blood contact in which both failed to follow CDC-recommended infection control procedures.

However, the reports causing the most concern involved three health-care workers reported by CDC in late May 1987 to have been infected following non-needlestick exposure to HIV-contaminated blood.[32] In the first of these three cases, an ungloved health-care worker with chapped hands was in direct contact for about 20 minutes with the blood of a patient later found to be infected with HIV. In the second case, a medical technologist, using a device for separation of blood components, spilled HIV-contaminated blood over most of her hands and forearms. Again, the worker was not wearing gloves and may have touched a patch of dermatitis on her ear, which may have resulted in blood contact with broken skin. In the third case, a health-care worker, filling a tube with the blood of an HIV-positive patient, was splattered with blood on her face and in her mouth. This worker was not wearing a mask or face shield and apparently was exposed by blood-to-mucous-membrane contact.[33]

Although CDC was unable to rule out all other possible risk factors in these three cases, the infections could very likely have been prevented if CDC-recommended procedures had been followed to prevent contact between HIV-infected blood and broken skin or mucous membranes. In Case One, the health-care worker had chapped hands and was not wearing gloves; in Case Two, the technologist was not wearing gloves and also touched a patch of dermatitis in her ear with contaminated hands; in Case Three, the worker was not wearing a mask or eye protection while working directly with blood.[34] While unbroken skin is an effective barrier against all micro-organisms, the proper use of gloves will provide the wearer with valuable protection should chafing, nicks, or other inapparent breaks be present on the hands.

Finally, concern may arise from the recent report of a laboratory worker infected with HIV.[35] This case involved a researcher who had had regular and prolonged contact in the laboratory with preparations of HIV much more highly concentrated than are found in normal samples of blood or body fluids. Investigators believe that the infection resulted from an incident or incidents similar to those experienced by the three health-care workers just discussed. It should be emphasized that the National Institutes of Health have tested hundreds of laboratory staff who have worked with HIV and this is the only known case of infection. Also, it is important to note that working with concentrated viruses in the laboratory is many orders of magnitude more hazardous than working in any normal clinical or correctional situation. Therefore, this incident of infection is not an accurate reflection of infectious hazards in any area of correction or law enforcement.

Perinatal Transmission

Perinatal transmission is the leading cause of AIDS among infants and small children. More than three-fourths of all children with AIDS have had at least one parent either with AIDS or in a group at high risk for HIV infection. Pediatric AIDS is closely associated with the infection of the mother and with intravenous drug abuse. Mothers of pediatric AIDS cases are predominantly intravenous drug abusers themselves, or the sexual partners of intravenous drug abusers. Most pediatric cases have been reported from New York City, northern New Jersey, and Florida. Blacks and Hispanics are dramatically over-represented among children with AIDS.

Infected mothers may transmit HIV to the fetus in utero, to the infant during labor and delivery, or to the infant shortly after birth through infected breast milk. The distribution of pediatric cases by these routes of transmission is not known, nor is the efficiency of perinatal HIV transmission. However, it is generally believed that 40-50 percent of infants born of infected mothers will themselves be infected by very early in life.[36]

No Transmission Through Casual Contact

The most critical point to convey in education and training programs regarding AIDS is that there is absolutely *no* evidence of the infection being transmitted by casual contact. CDC emphasizes that AIDS is not spread by sneezing, coughing, breathing, hugging, handshaking, sharing eating and drinking utensils, using the same toilet facilities or any other form of non-sexual contact or activity. The lists of non-dangerous contacts published by the CDC and by state and local public health agencies are not intended to be exhaustive. Indeed, it would be impossible to develop an exhaustive list. Therefore, if any particular type of contact is omitted from a list, this does not mean that it is dangerous. The critical point is that the virus has not been transmitted by any type of casual contact.

Strong evidence for the conclusion that HIV infection is not spread by casual or even intimate non-sexual contact comes from studies of family members of AIDS patients and of health-care workers who cared for AIDS patients, as well as from experience in other settings where close but non-sexual contact or ostensibly risky exposures have occurred. More than 50,000 cases of AIDS have now been reported to the CDC, and *not one* of them has occurred in a family member of another person with AIDS, unless that family member had independent risk factors. Seven separate studies totaling almost 500 family members of persons with AIDS have revealed *no* infections that could not be explained by independent risk factors.[37]

Studies of the type, duration, and frequency of household contact revealed important evidence, as well. These family members regularly shared dishes, cooking and eating utensils, toothbrushes, razors, toilets, beds, baths, kitchens, and many other places and objects with AIDS patients. In most households all clothing was washed together. The persons with AIDS and their family members also engaged in extensive and frequent non-sexual physical contact such as hugging, kissing on the cheek, and kissing on the lips. No special precautions against infection were taken in any of these contacts or activities. In most cases, sufficient time had elapsed between the start of household contact and the last evaluation of the family member for seroconversion to have occurred. Yet none, in fact, occurred.

No Transmission in Social or Occupational Settings

There is no evidence of HIV transmission as a result of normal social or occupational interaction in schools, offices, churches, or other settings. A study of hemophiliac and non-hemophiliac children in a French private school found that half of the former, but none of the latter had seroconverted. All these children had had "close casual contact, some of them for several years."[38]

There have been no documented cases of police officers, paramedics, or firefighters becoming infected with HIV as a result of rendering first aid or mouth-to-mouth resuscitation to an infected person or, in fact, through any job-related incident.

Finally, three annual NIJ surveys have identified no cases of correctional staff becoming infected or developing AIDS as a result of contact with an infected inmate.

Evidence Against Transmission Through Other Body Fluids and Through Biting Incidents

Despite the fact that contact with blood, semen, vaginal secretions, and breast milk continue to be the only known means of transmitting HIV, correctional staff have expressed concern that they might become infected by contact with other body fluids such as may occur in biting or spitting incidents. All evidence continues to point to the extreme unlikelihood of HIV transmission through such means.

HIV has been isolated in saliva, tears, and urine, although at much lower concentrations than in blood and semen. The virus has not been found in perspiration, feces, or vomitus. Researchers at Massachusetts General Hospital attempted to grow HIV from eighty-three saliva samples taken from seventy-one homosexual men, all of whom were HIV seropositive (twenty were healthy, thirty-two had ARC, and nineteen had AIDS). The actual virus could be grown from only one (1 percent) of these eighty-three saliva specimens. In contemporaneous studies, other researchers are reaching similar conclusions.[39] One study which found HIV in saliva has been criticized on the ground that the saliva samples were not drawn directly from the salivary glands, but from fluid already in the mouth, which may have contained blood. AIDS patients sometimes have intra-oral bleeding from gums and ulcers.[40]

Further evidence against transmission through saliva comes from the family member studies discussed above, and studies of dental workers. In the family member studies, subjects frequently kissed persons with AIDS and handled items soiled by their saliva without becoming infected. Although CDC cautions that there may be some theoretical risk involved in deep kissing in which saliva is exchanged, they note that there have been no reports of infection through such contact.[41]

The primary reason that transmission through saliva or urine is so unlikely is that HIV is found in such low concentrations in these body fluids. It has been estimated, for example, that *one quart* of saliva or urine would have to *enter the bloodstream* of an individual for infection to occur.[42]

Correctional officers and others who administer cardio-pulmonary resuscitation (CPR) may wonder why CDC recommends using masks or airways when performing CPR if saliva is not an efficient medium for HIV transmission and no cases of such transmission have been reported. The reason is that masks represent a reasonable precaution that also helps to prevent transmission of other infections that may be more efficiently transmitted through saliva.

Biting and spitting incidents may particularly concern correctional officers. Research findings on saliva should allay fears regarding the risk from spitting incidents and some of the fears regarding human bites. Biting may also involve blood contact, but it should be emphasized that it is typically the individual doing the biting who comes into contact with the blood of the victim, rather than the reverse. The victim cannot be infected by the blood of the person committing the bite unless that person somehow has blood in his or her mouth that then comes into contact with the victim's blood. There have been no reports of HIV transmission through biting. In one study of eighty-six family members of children with AIDS, no transmission of the virus occurred despite occasional biting of siblings. In addition, an adult with AIDS reportedly bit thirty health-care workers, none of whom became infected as a result.[43]

The possibility of transmission of HIV by food-service workers bleeding or spitting in food has caused concern in some correctional facilities as well as in the community at large. However, it would be very difficult for such transmission to occur and there are no documented cases of this kind. To be successfully transmitted through food, a sizable dose of the virus would first have to get into the food and then into someone else's mouth. This in itself is unlikely, but even if it happened the virus would probably be killed by stomach acids. This would be the likely outcome in the common hypothetical correctional scenario in which an infected inmate working in a food service assignment deliberately or accidentally spits or bleeds in the food. Because there is no evidence that the infection is transmitted through food, CDC specifically recommends against screening food service workers for antibody to HIV.

These research findings are all particularly important to the correctional setting because of concerns among inmates and correctional staff that HIV may be transmitted through human bites, urine-throwing incidents, contamination of food, and other such incidents that may occur in institutions. The research on family members and health-care workers with analogous exposures (and even ostensibly more serious exposures, such as needlesticks) indicates that these risks are extremely low.

Evidence Against Transmission by Insects

The possibility that HIV can be transmitted by mosquitoes, head lice, and other insects is periodically raised. Despite strong evidence against the possibility of such transmission, and the virtually unanimous agreement among medical researchers that it does not occur, even respected periodicals continue to keep the issue alive.[44]

Primary concern regarding insect transmission in the United States has focused on Belle Glade, Florida, an extremely poor community largely composed of black and Hispanic migrant workers with an unusually high concentration of HIV infection and AIDS. However, strong evidence against insect transmission comes from Belle Glade itself. Presumably, if insects transmit HIV, the infection would be found among children and the elderly—perhaps even more frequently among children than among other age groups because they spend more time outdoors. Yet, in Belle Glade, HIV infection is concentrated among age groups which are most likely to be sexually active and to abuse intravenous drugs. This strongly suggests that, in Belle Glade as elsewhere, sexual activity and needlesharing are the primary means of transmission.[45] Moreover, serologic studies revealed that HIV-infected persons in Belle Glade were no more likely than non-HIV-infected persons to have been exposed to other diseases typically transmitted by insects. If mosquitoes were transmitting HIV, one would expect to find a close correlation between persons infected with HIV and with other insect-borne diseases.

Insects may transmit infections in two ways—biologically and mechanically—and neither has been shown to be possible with HIV. Biological transmission requires that the insect ingest and replicate the virus in its own body and transmit it to humans through a bite. Laboratory studies show that mosquitoes do not replicate HIV or even retain it in their bodies. Mechanical transmission involves passage of the virus through blood that the insect draws from an infected person and that remains on the insect when it bites the next person. This is extremely unlikely to occur for several reasons. First, the amount of potentially involved blood is incredibly small. Second, an insect bite is much more superficial than a needlestick or other intravenous puncture in which the virus is injected directly into the blood stream. Third, insects bite to feed on blood, not to inject blood, and they feed infrequently – some believe only once a day. Thus, the likelihood that a mosquito or other insect will bite an HIV-infected person, acquire a sufficient amount of infected blood to transmit the virus, and find an uninfected person to bite before the blood dries and the virus is killed, is so small as to be negligible.

Prospects for Vaccines and Cures

Scientists have begun to make some significant progress in understanding the complex structure and behavior of HIV. Such knowledge is a prerequisite for developing an AIDS vaccine. However, the goal is extremely elusive and new knowledge about the virus as often frustrates as contributes to progress on vaccine development. HIV is a retrovirus, which means that it invades and incorporates itself into the genetic material. It is thus more hidden than an ordinary virus, and it tends to change its guise, rendering it, in effect, a "moving target" difficult to attack with a single, static vaccine.

Despite the difficulties, several vaccines are in development, and two have been approved for clinical trials. The first, Vaxsyn HIV-1, was approved in August 1987. This vaccine is hyphothesized to block certain viral proteins which bind to the receptor T-cell. Thus denied access, the virus cannot infect T-lymphocytes. This vaccine is being tested in sixty healthy seronegative male homosexuals, broken into four groups, each receiving a different dose. A control group, which will receive no vaccine, has also been recruited.

There are significant ethical problems with any HIV vaccine trial. First, the members of the control group are being denied whatever beneficial effects the vaccine may have. Second, the vaccine renders the recipient seropositive by current HIV antibody tests, and thus subject to possible discrimination and stigma. As a result, the investigators have issued all subjects certificates stating that they have been vaccinated and not infected with HIV. If the first phase of the trial – designed to determine the toxicity, not efficacy of the vaccine – goes satisfactorily, a second phase would investigate optimum dosages in a large population. A third phase, involving large populations, could begin in 1990. A second vaccine, developed by Oncogen of Seattle, Washington, was approved for clinical trials in November 1987.[46]

There has also been progress in the development of therapeutic drugs. Zidovudine (azidothymidine [AZT]) was approved by the Food and Drug Administration in 1987 for treatment of AIDS patients with advanced illness characterized by *Pneumocystis carinii* pneumonia, and symptomatic cases of AIDS-related complex (ARC). AZT was not originally approved for use in persons with other indicator diseases or with asymptomatic HIV infection. This was because the drug is very toxic and has serious side-effects in some patients, including severe anemia and other blood problems. Very recently, however, the manufacturer of AZT, Burroughs Wellcome Company, has indicated that the drug may be able to retard the onset of illness in asymptomatic individuals. Clinical trials of AZT in asymptomatically infected individuals are in progress, but enrollment of participants has been slow, and the results may not be known for several years.[47]

In one clinical trial, patients receiving AZT were found to have prolonged short-term survival, reduced frequency of opportunistic infections, increased T-4 helper cell counts, and weight gain. However, it must be emphasized that AZT *does not cure AIDS*. It does not reverse the underlying immune deficiency which renders the patient susceptible to opportunistic infections and cancers.[48]

Research on therapeutic drugs has suffered setbacks. There have also been prematurely dramatic announcements of therapeutic success, which later had to be retracted or qualified. Several drugs originally thought to hold promise, such as suramin, have been found to be ineffective. In general, prospects for a vaccine or cure for AIDS remain less than promising for the immediate future. The National Academy of Sciences concluded that the probability of an effective vaccine becoming available in the next five-ten years is "low." The report also concludes that "development of therapy for HIV infection will most likely be a difficult and long-term process, with no presently available guarantees of success."[49] The poor prospects for vaccines or cures in the foreseeable future only serve to underline the importance of educational efforts. As many have already stated, education is the only available weapon against AIDS.

Notes

1. The incidence rate per 100,000 population is a standard measure used to facilitate comparisons. The incidence rates for the population at large were calculated as follows:

$$\text{incidence rate} = \frac{\text{total number of cases reported to CDC in 1987 x 100,000}}{\text{total population of U.S.}}$$

2. Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care, and Research* (Washington, D.C., 1986), p. 41.

3. Harry W. Haverkos, "Factors Associated with the Pathogenesis of AIDS," *Journal of Infectious Diseases*, July 1987; 156:251-257.

4. *Confronting AIDS*, p. 45; A. Ranki et al., "Long Latency Precedes Overt Seroconversion in Sexually Transmitted HIV Infection," *Lancet*, September 12, 1987; 2:589-593.

5. CDC, "Transfusion-Associated HTLV-III/LAV Infection from a Seronegative Donor – Colorado," *Morbidity and Mortality Weekly Report* (MMWR) June 20, 1986; 35:389-391; Thomas Peterman, M.D. (CDC). Presentation at 10th National Conference on Correctional Health Care, Washington, D.C., October 31, 1986; Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care and Research* (Washington, DC, 1986), p. 54.

6. CDC, "Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS," *MMWR*, August 14, 1987; 36:510.

7. D.C. Des Jarlais and S.R. Friedman, "Target Groups for Preventing AIDS Among Intravenous Drug Users," Draft, Narcotic and Drug Research, Inc., New York, 1986.

8. *Confronting AIDS*, p. 46.

9. The most recent revision was published in *MMWR*, August 14, 1987; 36:35-155.

10. CDC, "AIDS Weekly Surveillance Report – United States," December 28, 1987.

11. *MMWR* 1985; 34:573-575. H.W. Jaffe et al., "AIDS in a Cohort of Homosexual Men: A Six-Year Follow-Up Study," *Annals of Internal Medicine* 1985; 103:210-214; J.J. Goedert et al., "Determinants of Retrovirus (HTLV-III) Antibody and Immunodeficiency in Homosexual Men," *Lancet* 1984; 2:711-716; L.A. Kingsley, et al; "Risk Factors for Seroconversion to HIV Among Male Homosexuals," *Lancet* 1987; 1:345-349; W. Winkelstein, "Sexual Practices and Risk of Infection by HIV: The San Francisco Men's Health Study," *Journal of the American Medical Association*, 1987; 257:321-325.

12. *Confronting AIDS*, pp. 44, 91.

13. Haverkos, "Factors Associated with the Pathogenesis of AIDS."

14. G.H. Friedland and R.S. Klein, "Transmission of the Human Immunodeficiency Virus," *New England Journal of Medicine*, October 29, 1987; 317:1125-1135.

15. Cited in Janice Hopkins Tanne, "The Last Word on Avoiding AIDS," *New York Magazine*, October 7, 1985.

16. CDC, "AIDS Weekly Surveillance Report – United States," November 16, 1987.

17. R. Rothenburg, et al., "Survival with AIDS," *New England Journal of Medicine*, November 19, 1987; 317:1297-1302.

18. "AIDS Fears Persist," *Medical World News*, November 23, 1987, p. 39.

19. Friedland et al., "Transmission of HIV," p. 1125. This article provides an excellent summary of knowledge on the transmission of HIV infection.

20. This conclusion is based on a comparison of studies of health-care workers exposed to the Hepatitis-B virus and HIV through needlesticks and other sharp instrument injuries. Friedland, "Transmission of HIV," p. 1127.

21. Friedland, "Transmission of HIV," p. 1129.

22. R.J. Biggar, "The AIDS problem in Africa," *Lancet*, January 11, 1986:79-83; D.M. Barnes, "AIDS Research in New Phase," *Science*, July 18, 1986:283.

23. "HTLV-III/LAV Antibody Prevalence in U.S. Military Recruit Applicants," *MMWR*, July 4, 1986; 35:421-424. D.S. Burke, et al., "HIV Infections Among Civilian Applicants for U.S. Military Service," October 1985 to March 1986," *New England Journal of Medicine*, July 16, 1987; 317:131-136.

24. See, for example, M.A. Fumento, "AIDS: Are Heterosexuals at Risk?," *Commentary*, November 1987; p. 25.

25. Fumento, "Are Heterosexuals at Risk?," p. 24.

26. Colin Norman, "AIDS Trends: Projections from Limited Data," *Science*, November 29, 1985; 230:1021.

27. Friedland, "Transmission of HIV," p. 1130.

28. Friedland, "Transmission of HIV," p. 1129.

29. The following paragraphs are taken from D.C. Des Jarlais and D. Hunt, "AIDS Bulletin: AIDS and Intravenous Drug Use," (Washington: National Institute of Justice, U.S. Department of Justice, 1988).

30. Friedland, "Transmission of HIV," 1120-1127; Hirsch, et al., "Risk of Nosocomial Infection with HTLV-III;" Weiss et al. "HTLV-III Infection among Health-Care Workers;" Henderson, et al., "Risk of Nosocomial Injection with HTLV-III/LAV;" Gerberding, et al., "Risk of Transmitting HIV;" McCray et al., "Occupational Risk of AIDS Among Health-Care Workers."

31. Hirsch, et al., "Risk of Nosocomial Infection with HTLV-III;" Weiss et al., "HTLV-III infection Among Health-Care workers;" Henderson, et al., "Risk of Nosocomial Injection with HTLV-III/LAV;" Gerberding, et al., "Risk of Transmitting HIV;" McCray et al., "Occupational Risk of AIDS Among Health-Care Workers."

32. Update: "HIV Infections in Health-Care Workers Exposed to Blood or Infected Patients," *MMWR*, May 22, 1987; 36:285-288.

33. Update: "HIV Infections in Health-Care Workers."

34. For precautionary guidelines, see "Recommendations for the Prevention of HIV Transmission in Health-Care Settings," *MMWR*, August 21, 1987; 36:35-185.

35. National Institutes of Health, unpublished data.

36. Friedland, "Transmission of HIV," p. 1130-1131.

37. Friedland, "Transmission of HIV," p. 1132.

38. Berthier, A., et al., "Transmissibility of HIV in Hemophiliac and Non-Hemophiliac Children Living in a Private School in France," *Lancet*, September 13, 1986, p. 598-601.

39. D.D. Ho et al., "Letter: Infrequency of Isolation of HTLV-III virus from Saliva in AIDS," *New England Journal of Medicine*, December 19, 1985, p. 1606.

40. Nicholas Dello Russo, "Inaccuracies About AIDS Lead to Hysteria," Letter to the Editor, *Boston Globe*, November 12, 1986, p. 14.

41. Friedland, "Transmission of HIV," p. 1132; Gerberding, et al., "Risk of Transmitting HIV;" R.S. Klein, et al., "Prevalence of Antibodies to HTLV-III/LAV Among Dental Professionals." Presented at the 26th Interscience Conference on Antimicrobial Agents and Chemotherapy, New Orleans, September 28 - October 1, 1986.

42. Alvin Novick, M.D., Yale University, presentation at National Institute on Sentencing Alternatives/National Institute of Corrections Workshop on AIDS—Policy and Treatment Dilemmas for Residential Community Corrections Programs, Newton, Mass., September 21, 1987.

43. M.F. Rogers, et al., "Can Children Transmit HTLV-III/LAV Infections?" Presented at the Second International Conference on AIDS, Paris, June 23-25, 1986; C. Tsoukas, et al., "Risk of Transmission of HTLV-III/LAV from Human Bites." Presented at the Second International Conference on AIDS, Paris, June 23-25, 1986.

44. See, for example, Katie Leishman, "AIDS and Insects: Epidemiological Puzzles," *The Atlantic*, September 1987; 260: 56-72.

45. "AIDS in Western Palm Beach County, Florida," *MMWR*, 1986; 35: 609-612.

46. B. Merz, "HIV Vaccine Approved for Clinical Trials," *Journal of the American Medical Association*, September 18, 1987; 258: 1433-1434; Buraff Publications, *AIDS Policy and Law* December 2, 1987; 2:8.

47. Philip M. Boffey, "Trial of AIDS Drug in U.S. Lags as Too Few Participants Enroll," *New York Times*, December 28, 1987.

48. I. Brook, "Approval of Zidovudine (AZT) for AIDS," *Journal of the American Medical Association*, September 18, 1987; 258: 1517.

49. *Confronting AIDS*, pp. 219, 229.

Chapter 2: The Epidemiology of HIV Infection and AIDS in Correctional Facilities and the Population at Large

This chapter presents basic epidemiological information on HIV infection and AIDS in the American population as a whole, and in correctional populations in the United States and Canada. For the population at large, the chapter presents the current and likely future dimensions of the epidemic, and discusses the breakdown of cases by region, demographic characteristics, and transmission categories. Three successive NIJ surveys have failed to identify a single job-related case of HIV infection or AIDS among correctional staff. For correctional inmates, distribution of AIDS cases by systems, regions, transmission categories, and demographic characteristics are presented. The chapter also discusses the prevalence of ARC and HIV seropositivity among inmates and synthesizes available information on the transmission of HIV in prisons.

HIV Infection and AIDS in the Population at Large

The dimensions of the AIDS problem in the United States continue to grow alarmingly. On January 4, 1988 the 50,000th case in the United States was reported to CDC. There have been over 700 pediatric cases. Through the end of 1987, almost 28,000 persons had died of AIDS in the United States.[1] In Canada, 1300 adult cases and twenty six pediatric cases had been reported as of November 1, 1987. There had been 699 deaths.[2]

New York State and California together account for almost 50 percent of the AIDS cases in the United States, while New Jersey, Florida, and Texas collectively account for another 21 percent. Within these states, as elsewhere, cases are heavily concentrated in cities and major metropolitan areas. In addition to confirmed AIDS cases, the National Academy of Sciences estimates that there may be as many as 50,000 to 125,000 cases of AIDS-Related Complex in the United States and the U.S. Public Health Service estimates that there are 1-1.5 million asymptomatic HIV infected individuals. CDC believes 270,000 AIDS cases will have been diagnosed in the United States by the end of 1991 and that, by that year, over 50,000 people will be dying of AIDS each year—more than were killed in the entire Vietnam War.[3]

Ninety-two percent of all American AIDS cases have been in males and 88 percent of the cases have been in persons aged 20-49 years. In Canada, males represent 94 percent of cases, and 88 percent of cases have been in persons aged 20-49 years. There still have been very few AIDS cases among adolescents in the United States or Canada (less than 1 percent are in persons 13-19 years old). Yet, some consider this age group at particular risk for HIV infection and illness in the next few years, because of the prevalence of careless sexual practices among adolescents and the growth of intravenous drug use among teenagers in some areas of the country.

The overall racial/ethnic distribution of adult cases in the United States has remained essentially the same since 1985: White - 60 percent; Black - 25 percent; Hispanic - 14 percent; Other/unknown - 1 percent. Blacks and Hispanics (12 percent and 7 percent, respectively, of the American population as a whole) are thus disproportionately represented. Blacks and Hispanics are particularly overrepresented among women with AIDS (51 percent and 20 percent, respectively) and among pediatric cases (54 percent and 23 percent, respectively).[4] Many of the minority women with AIDS are intravenous drug abusers or sexual partners of male intravenous drug abusers.

The most recent CDC breakdown of confirmed AIDS cases in the United States by transmission category is shown in Figure 2.1. There is an overlap of approximately 8 percent between the homosexual/bisexual and intravenous drug abuser categories. Thus, about 25 percent of reported adult AIDS cases are in persons with some history of intravenous drug abuse and about 74 percent of cases have been in homosexual/bisexual males. The only change in the risk group distribution since 1985 was a 3-percent decrease in the "other/unclassified" category and a corresponding increase in the heterosexual partner category. This represented a shift of Haitian-born persons from the former to the latter category based on the belief that heterosexual transmission is prevalent in Haiti.

Many epidemiologists believe the percentage of cases attributed to intravenous drug abuse is likely to grow dramatically in the next few years. Moreover, they believe the greatest threat for significant spread of infection to the heterosexual population is through infection of the female sexual partners of intravenous drug users. This, in turn, suggests that perinatal transmission of HIV may become an increasingly serious problem.

The "undetermined" cases are thought to have had known risk factors, but information on these factors

Figure 2.1

BREAKDOWN OF ADULT/ADOLESCENT AIDS CASES IN THE U.S.
BY TRANSMISSION CATEGORIES

Transmission Category	Number of Cases	Percent of All Cases
Homosexual/Bisexual Male	31,825	65%
Intravenous (IV) Drug Abuser	8,411	17
Homosexual Male and IV Drug Abuser	3,689	8
Hemophiliac	484	1
Heterosexual Cases	1,964	4
Transfusion Recipients	1,124	2
Undetermined	1,509[a]	3
Total	49,006	100%

---

[a] These individuals are thought to have had known risk factors, but information on these factors was not available for various reasons—e.g., they died before they could be interviewed, they refused to be interviewed, or they had forgotten or failed to admit high-risk behaviors.

Source: CDC, AIDS Weekly Surveillance Report — United States, December 28, 1987.

was unavailable for various reasons—e.g., the individuals could not be interviewed before they died, they refused to be interviewed, or they had forgotten or failed to admit activities involving possible exposure.

In Canada, 82 percent of cases have been in homosexual or bisexual males and 3 percent in persons with a history of IV drug use.

The latest medical research and epidemiological data together show that AIDS is a very serious and growing problem, but also that HIV is transmissible only by homosexual and heterosexual activity, blood-to-blood contact, and perinatal events. In all settings, including correctional agencies, the response to AIDS should stress both of these facts. Education and prevention programs which rationally address the real nature and extent of the risk should be implemented. It is equally dangerous to take a complacent or an alarmist approach to this problem.

HIV Infection and AIDS in Correctional Facilities

No Job-Related Cases of HIV Infection or AIDS Among Correctional Staff

Correctional staff in almost every jurisdiction have expressed concern about the possibility of contracting HIV infection or AIDS from inmates in the institutions. However, responses to three successive NIJ surveys indicate that there are no known cases of AIDS, ARC, or HIV seropositivity among correctional staff as a result of contact with inmates. Hennepin County (Minneapolis), Minnesota tested six correctional officers who claimed to have been potentially exposed to infection in on-the-job incidents. These incidents included needlesticks and fights in which blood was drawn. None of the officers tested positive. Similarly, the Oklahoma correctional system tested ten officers involved in potential transmission incidents, and Oregon tested seven officers; none were found to be HIV-seropositive. Neither have there been any job-related cases of infection among police officers, firefighters, emergency medical technicians, or any other public safety workers.

Survey respondents reported seventeen cases of AIDS among current or former staff members, but none of these individuals had been involved in incidents with inmates in which transmission of the infection could have occurred. Rather, these staff members became infected through behavior totally independent of their jobs. When an officer at New York's Sing Sing facility developed AIDS, correctional authorities immediately investigated and determined that the infection had resulted from independent risk factors. This informa-

38

Figure 2.2

CUMULATIVE TOTAL AIDS CASES AMONG U.S. CORRECTIONAL INMATES AND THE U.S. POPULATION AT LARGE, 1985-1987

	November 1985	October 1986	Percent Increase 1985-86	October 1987	Percent Increase 1986-87
Correctional Cases	766	1,232	61%	1,964	59%
Cases in Population at Large[a]	14,519	26,002	79	41,770	61

---

[a] Adult/adolescent cases. Pediatric cases excluded.

Source: CDC, AIDS Weekly Surveillance Reports – United States, November 4, 1985; October 6, 1986; October 5, 1987; NIJ Questionnaire Responses.

tion was quickly presented to the staff, effectively quelling concerns that the officer had been infected on the job. Indeed, education and training should stress that staff need to take care to avoid infection both on the job and in their private lives. In the climate of fear that may exist among officers in some correctional systems, there may be too much emphasis on the possibility of job-related infection and insufficient attention to the (probably greater) possibility of infection through private activity.

AIDS Cases Among Correctional Inmates

As of October 1, 1987, there had been a cumulative total of 1,964 confirmed AIDS cases among inmates in seventy responding federal, state, and local correctional systems in the United States (Figure 2.2). There had been 1,320 cases in thirty-nine state and federal correctional systems—up 190 percent from the 455 cases reported as of November 1, 1985, the time of the original survey, and up 68 percent from the 784 cases reported as of October 1, 1986. Thirty-one responding city and county jail systems reported 644 cases—up 107 percent from the 311 cases reported in the original survey in 1985 and up 44 percent from the 448 cases reported in 1986. Total AIDS cases in all responding American correctional systems thus increased from 766 to 1,964—or 156 percent—in the two years since the first survey and 59 percent in the one year since the second survey. This is a large increase in cases, but it is, in fact, slightly lower than the 61 percent national increase from 28,002 cases to 41,770 during the same period (October 1986 to October 1987).[5] As shown in Figure 2.2, the growth in AIDS cases was slightly slower in correctional systems than in the population at large both between 1985-1986 and 1986-1987. Moreover, it should be noted that the NIJ survey results probably include some double-counting of cases—that is, individuals who were known to have AIDS while they were in county jail and then entered a state institution. These cases would probably have been counted by both the county and state correctional systems.

In Canada, a cumulative total of two cases was reported by the federal system and thirteen cases by provincial systems.

The figures above are *cumulative* totals—that is, all cases reported since the correctional systems began keeping records. Thirty-nine state and federal systems in the United States reported 295 *current* cases of AIDS among inmates, while thirty-one responding city and county systems reported 126 *current* cases. There were four cases in Canadian systems as of October 1, 1987.

State and federal systems in the United States report that a cumulative total of 716 inmates have died from AIDS while in custody; responding city and county systems in the U.S. report 159 inmate deaths. Of 875 total inmate AIDS deaths in the United States, 346—or 40 percent—have occurred since the 1986 survey was taken. Canadian correctional systems report three deaths among inmates.

The distribution of cumulative total AIDS cases across correctional systems in the United States is still quite skewed (Figure 2.3), although not so uneven as in the first two surveys. While twelve more systems than last year reported at least one case, more than 70 percent of state and federal systems and almost two-thirds of the responding city and county systems still have had fewer than ten cases. At the other extreme, only six state and federal systems and one responding city or county system have had more than fifty cases. Four state systems (8 percent) account for 73 percent of the cumulative total AIDS cases, while four of the re-

Figure 2.3

DISTRIBUTION OF CONFIRMED AIDS CASES AMONG INMATES, BY TYPE OF SYSTEM, UNITED STATES

State/Federal Prison Systems

Range of Total AIDS Cases	Original Survey: November 1985				Third Survey: October 1987			
	n systems	%	n cases	%	n systems	%	n cases	%
0	26	51%	0	0%	12	23%	0	0%
1-3	15	29	24	5	20	39	37	3
4-10	5	10	30	7	5	10	33	3
11-25	2	4	42	9	7	14	101	8
26-50	1	2	33	7	1	2	32	2
51-100	1	2	95	21	2	4	158	12
>100	1	2	231	51	4	8	959	73
Total	51	100%	455	100%	51	100%	1,320	100%[a]

City/County Jail Systems

Range of Total AIDS Cases	Original Survey: November 1985				Third Survey: October 1987			
	n systems	%	n cases	%	n systems	%	n cases	%
0	13	39%	0	0%	2	6%	0	0%
1-3	10	30	16	5	7	21	13	2
4-10	7	21	43	14	12	36	81	13
11-25	1	3	12	4	8	24	120	19
26-50	1	3	40	13	3	9	115	18
51-100	0	0	0	0	0	0	0	0
>100	1	3	200	64	1	3	315	49
Total	33	99%[a]	311	100%	33	99%[a]	644	101%[a]

Source: NIJ/ACA Questionnaire Responses.

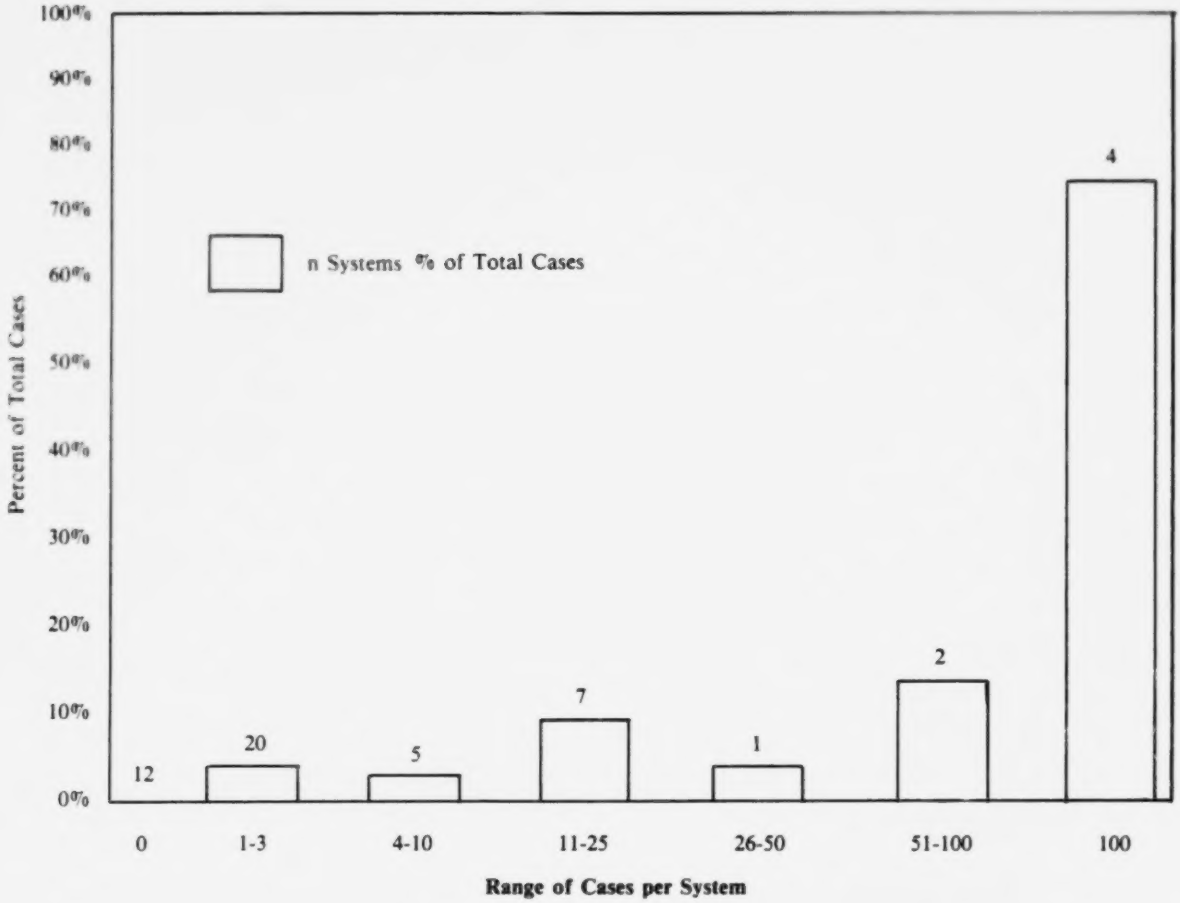
[a] Due to rounding.

sponding city and county systems (12 percent) contribute 67 percent of the cases. These distributions are depicted graphically in Figures 2.4 and 2.5.

The Middle Atlantic states still account for the vast majority of AIDS cases among correctional inmates (Figure 2.6). Sixty-two percent of state systems' cases and 57 percent of cases in responding city and county systems have been in the Middle Atlantic region. However, it should be noted that correctional AIDS cases have increased in all regions since the original survey was taken and the regional distribution is less uneven than it was several years ago. More and more correctional systems are likely to experience AIDS cases each year, although the overall distribution of

Figure 2.4

DISTRIBUTION OF CUMULATIVE TOTAL AIDS CASES, OCTOBER 1987
Across State/Federal Prison Systems



cases will probably remain somewhat skewed across correctional systems and geographic regions.

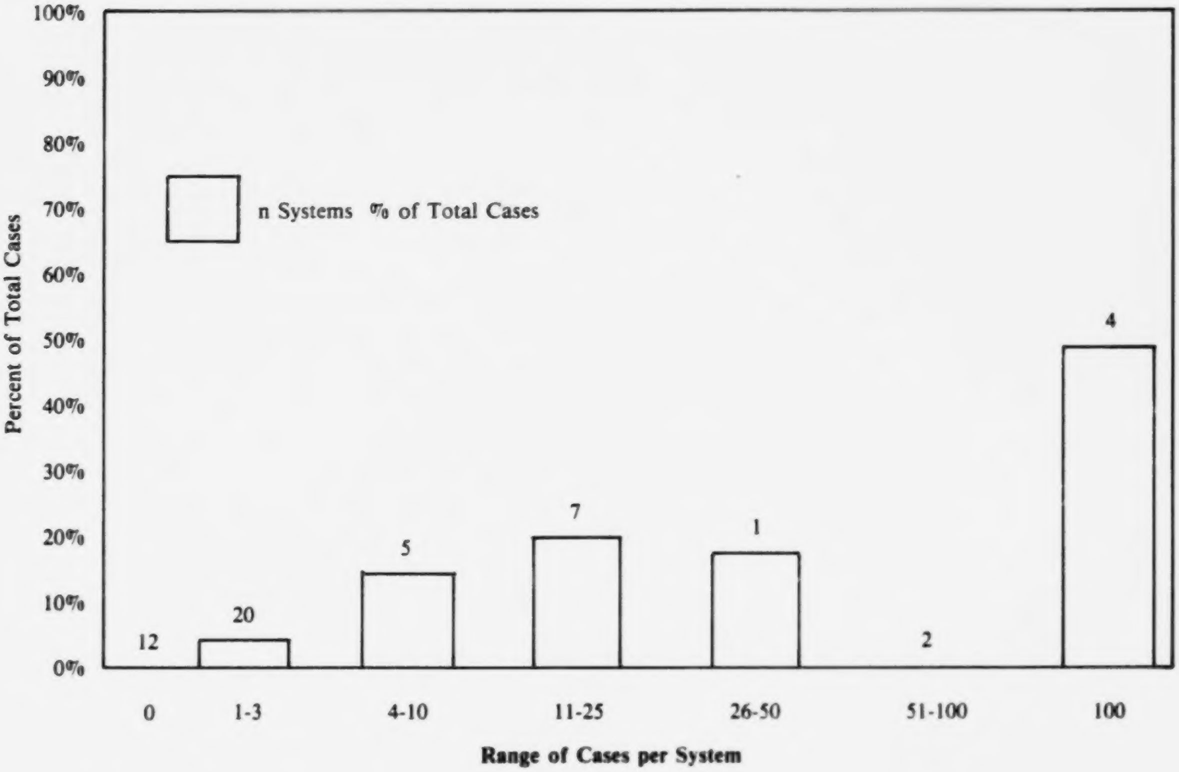
The incidence rate of AIDS in the entire United States population was 8.6 cases per 100,000 persons in 1987,[6] up from 5.3 in 1986 and 3.4 in 1985. Incidence rates for individual states range from zero to twenty-three, with most under three. In state and federal correctional systems, incidence rates ranged from zero to 230, although two-thirds of the states have rates less than twenty-five and only two have rates over 100. The aggregate incidence rate for all state/federal systems was fifty-four cases per 100,000 inmates.[7] Rates in city and county jail systems vary from zero to 1,280 cases per 100,000, but one-half of the jurisdictions have rates under twenty-five. The aggregate incidence rate for all responding city/county systems was 126 cases per 100,000 inmates. Rapid population turnover makes these jail incidence statistics extremely suspect. In general, the profile of incidence rates in correctional systems was quite similar in 1986 and 1987. The aggregate incidence rate for all Canadian inmates was thirteen per 100,000, substantially lower than in the United States.

Incidence rates are predictably higher in correctional systems than in the population at large because of the concentration in inmate populations of persons with histories of high-risk behavior, particularly intravenous drug use. Moreover, the method of calculating incidence rates per 100,000 population guarantees that a correctional system with a very small number of AIDS cases – the typical case – will have a somewhat higher rate than a much larger outside population with substantially more AIDS cases.

The wide range in incidence rates obviously reflects the uneven distribution of AIDS cases across correc-

Figure 2.5

DISTRIBUTION OF CUMULATIVE TOTAL AIDS CASES, OCTOBER 1987
Across City/County Jail Systems



tional systems. The jurisdictions with the highest incidence rates continue to be in the Middle Atlantic region, where HIV infection is pervasive among intravenous drug users who are dramatically overrepresented in correctional institutions.

It should also be noted that there are wide variations in the incidence of AIDS in the general population both within and across states. For example, there are particularly high incidence rates in the New York City/Northern New Jersey metropolitan area. These are almost certainly associated with widespread needlesharing among intravenous drug users in "shooting galleries" and elsewhere.

Characteristics of Inmate AIDS Cases

The vast majority of inmate AIDS cases in the United States have been among men (95 percent), although cases are now appearing among women as well (95 cases or 5 percent). In Canada, the sex breakdown is 93 percent male inmates and 7 percent female inmates. American correctional systems were only able to provide racial/ethnic breakdowns covering 30 percent of cumulative total cases, and several of the jurisdictions with large numbers of cases were unable to provide this information. However, of the cases so classified, 32 percent were among whites, 58 percent among blacks, and 10 percent among Hispanics. All of the Canadian cases have been among whites.

Virtually all inmate AIDS cases are thought to be related to intravenous drug abuse or sexual activity. On average, correctional systems attributed two-thirds of their male cases to IV drug abuse and 43 percent to homosexual activity. Predictably, female cases were overwhelmingly (92 percent, on average) attributed to IV drug use. However, it is important to note that in some correctional systems, particularly those in the Middle Atlantic region, the percentage of all cases attributed to IV drug abuse is much higher than elsewhere. Of course, these are also among the systems with the largest number of inmate AIDS cases. In general, intravenous drug abuse is a much more im-

Figure 2.6

REGIONAL DISTRIBUTION OF TOTAL AIDS CASES BY TYPE OF SYSTEM, UNITED STATES

(Federal Bureau of Prisons Excluded)

State Prison Systems

	Original Survey: November 1985		Third Survey: October 1987	
Region	n cases	% of total	n cases	% of total
New England[a]	16	3.7%	56	4.6%
Mid-Atlantic[b]	327	75.5	762	62.3
E.N. Central[c]	6	1.4	31	2.5
W.N. Central[d]	0	0.0	6	0.5
S. Atlantic[e]	49	11.3	175	14.3
E.S. Central[f]	1	0.2	10	0.8
W.S. Central[g]	12	2.8	64	5.2
Mountain[h]	2	0.5	9	0.7
Pacific[i]	20	4.6	110	9.0
Total	433	100.0%	1,223	99.9%[j]

City/County Jail Systems

Region	n cases	% of total	n cases	% of total
New England[a]	0	0.0%	0	0.0%
Mid-Atlantic[b]	222	71.4	368	57.1
E.N. Central[c]	8	2.6	38	5.9
W.N. Central[d]	1	0.3	4	0.6
S. Atlantic[e]	24	7.7	72	11.1
E.S. Central[f]	0	0.0	3	0.5
W.S. Central[g]	3	1.0	10	1.6
Mountain[h]	1	0.3	10	1.6
Pacific[i]	52	16.7	139	21.6
Total	311	100.0%	644	100%

[a] Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut

[b] New York, New Jersey, Pennsylvania

[c] Ohio, Indiana, Illinois, Michigan, Wisconsin

[d] Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas

[e] Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida

[f] Kentucky, Tennessee, Alabama, Mississippi

[g] Arkansas, Louisiana, Oklahoma, Texas

[h] Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada

[i] Washington, Oregon, California, Alaska, Hawaii

[j] Due to rounding.

Source: NIJ Questionnaire Responses.

portant transmission category in correctional AIDS cases than in AIDS in the population at large. Fully 96 percent of cases in the New York State correctional system are intravenous drug abusers, as opposed to 34 percent of cases in the New York State population at large.[8] This is not surprising, given the high prevalence of intravenous drug abuse among criminal offenders. In addition, there is already a particularly high incidence of AIDS among intravenous drug abusers in the New York City/Northern New Jersey area. A study of 326 inmate deaths from AIDS in the New York State correctional system reveals some striking demographic information. Ninety-six percent were males, and 75 percent were between 25 and 39 years old. Fully 95 percent of these inmates admitted to intravenous drug abuse, 45 percent were Hispanic, 43 percent were black, only 12 percent were white, and 87 percent came from New York City.[9] Because Hispanics and Blacks are overrepresented among intravenous drug abusers, state correctional officials believe that this breakdown reflects the strong correlation between intravenous drug abuse and AIDS both in the state population at large and in the state correctional population.

AIDS-Related Complex (ARC) Among Correctional Inmates

Because of definitional variations and uneven recordkeeping, it is difficult to estimate the number of ARC cases among inmates. Several of the jurisdictions with the largest numbers of AIDS cases still do not maintain figures on ARC. Thus, available statistics on ARC are probably artificially low. NIJ survey responses report 498 current ARC cases in state and federal systems in the United States, and eighty-one current cases in city and county systems in the United States. Canadian correctional systems report six cases of ARC.

HIV Seroprevalence Among Correctional Inmates

There has been a great deal of speculation about the prevalence of asymptomatic HIV infection among correctional inmates. As discussed in Chapter Four, an increasing number of jurisdictions have instituted HIV antibody screening and testing programs. Some of these jurisdictions screen all inmates or all identified members of AIDS risk groups and link results with individual inmates; others have conducted (or are planning to conduct) blind epidemiological studies in which test results are never linked with individual subjects. Such epidemiological studies are underway in Illinois and Maryland; New York State and a number of other states are about to begin studies.

Many survey respondents provided aggregate results from their screening and testing programs. Most programs are small-scale, involving some combination of inmates with clinical indications, those in risk groups, and those who request testing. Data from such testing programs cannot be used to suggest seroprevalence because of the biases introduced in the selection process. However, ten states and the Federal Bureau of Prisons reported aggregate results of mass screening programs, six jurisdictions reported the results of "risk group" screening, five jurisdictions reported the results of blind epidemiological studies and six jurisdictions reported results from other large-scale testing programs. These results are shown in Figures 2.7 - 2.10.

Figure 2.7 shows that seroprevalence rates among new, current and about-to-be released inmates in mass screening jurisdictions were very low—from 0 to 2.6 percent, with all but five of the groups under 1 percent. Most of these are comparable to estimated seroprevalence rates in the population at large. Six jurisdictions reported the results of large-scale screening of "risk-group" members—generally homosexuals and intravenous drug abusers—which are shown in Figure 2.8. In one county jail system, all female prostitutes were tested at intake. In general, seroprevalence rates in these risk groups were higher than among all inmates, but in all but one jurisdiction (33%), they were 4 percent or less.

Figure 2.9 shows that, of all jurisdictions reporting the results of blind epidemiological studies, Maryland found the highest seroprevalence rates—7 percent among incoming men and 15 percent among incoming women. These rates have held remarkably constant for three annual studies.[10] The higher rate is attributed to the fact that a larger percentage of female inmates than male inmates in Maryland have histories of intravenous drug abuse. Otherwise, the seroprevalence rates found in epidemiological studies were below 1 percent, including 0.9 percent in Michigan, a state with a significant urban IV-drug using population.

Finally, Figure 2.10 presents results from other testing programs in six jurisdictions. These include testing of prospective participants in plasmapheresis programs, and of inmates who request or volunteer to be tested. These seroprevalence rates are also quite low.

Figure 2.7

RESULTS OF MASS SCREENING PROGRAMS IN CORRECTIONAL FACILITIES[a]

Jurisdiction	Number Tested	Inmate category(ies)	Number HIV Seropositive	% Seropositive
Alabama	275	all new inmates	4	1.5%
Colorado	5112	all new inmates	43	0.8
Idaho	163	all new inmates	0	0.0
Iowa	1925	all new inmates (1/1/87-9/30/87)	7	0.4
Missouri	1540	all new inmates (7/1/87-10/2/87)	6	0.4
Nebraska	812	all new inmates	2	0.2
Nevada	6021	all new inmates (9/85-12/87)	81	1.3
Nevada	3820	current inmates (8/85-9/85)	96	2.5
Oklahoma	2308	all new inmates	10	0.4
Oklahoma	9820	all current inmates (6/87)	41	0.4
South Dakota	1025	all new inmates (7/87)	1	0.1
South Dakota	982	all current inmates (7/87)	2	0.2
West Virginia	300	current inmates	2	0.6
Federal Bureau of Prisons	9640	all new inmates (6/87-10/87)	240	2.5
Federal Bureau of Prisons	5100	all releasees (6/87-12/87)	133	2.6

---

[a] Unless otherwise noted, all data are current as of October 1987.

Transmission of HIV Infection in Correctional Institutions

The issue of transmission of HIV infection in prisons and jails is a complex one, whose handling is very important in the overall management of the AIDS problem in correctional systems. The complexity is largely due to the length and variability of the incubation period of AIDS, which make it difficult to know exactly when transmission of the virus occurred. There is sharp debate on the subject, but little hard data as yet. Currently available data suggest low rates of transmission within correctional facilities.

The United States Army conducted follow-up testing of 542 inmates of a military prison who had been HIV-seronegative on intake during 1983-1984. The follow-up testing was done in July 1985, after most of the inmates had been incarcerated between one and two years. *None* had seroconverted.[11]

In 1985, Maryland conducted voluntary testing of 137 inmates in one facility who had been continuously incarcerated for seven years or more. The testing revealed two confirmed seropositives (1.5%). Because of their continuous incarceration since before the virus appeared in the United States, these two inmates are

Figure 2.8

RESULTS OF "RISK GROUP" SCREENING PROGRAMS IN CORRECTIONAL FACILITIES[a]

Jurisdiction	Number Tested	Inmate category(ies)	Number HIV Seropositive	% Seropositive
Alabama	770	sex offenders, homosexuals, IV drug users, pregnant females (5/86-1/87)	11	1.4
Kansas	150	unspecified risk groups	6	4.0
New Hampshire	128	homosexuals, IV drug users (10/85-11/86)	5	3.9
Harris County, (Houston), TX	526	unspecified risk groups (10/86-10/87)	175	33.3
Hennepin County, (Minn), MN	526	homosexuals, IV drug users	10	1.9
Orange County, CA	978	female prostitutes (3/85-10/86)	28	2.9

---

[a] Unless otherwise noted, all data are current as of October 1987.

Figure 2.9

RESULTS OF BLIND EPIDEMIOLOGICAL STUDIES IN CORRECTIONAL FACILITIES

Jurisdiction	Number Tested	Inmate category(ies)	Number HIV Seropositive	% Seropositive
Indiana	602	all new inmates (5/87-7/87)	1	0.2%
Maryland	748	all new male inmates (4/85-6/85)	52	7.0[a]
Maryland	39	all new female inmates (4/85-6/85)	6	15.4[a]
Michigan	571	all new inmates (11/86)	5	0.9
Wisconsin	997	all new inmates (1986)	3	0.3
King County, (Seattle), WA	199	all inmates visiting clinic (3/87-6/87)	0	0.0

---

[a] These percentages have held constant in two subsequent intake seroprevalence studies done in 1986 and 1987.

Figure 2.10

RESULTS OF OTHER HIV ANTIBODY TESTING PROGRAMS IN CORRECTIONAL FACILITIES[a]

Jurisdiction	Number Tested	Inmate category(ies)	Number HIV Seropositive	% Seropositive
Arkansas	3900	plasmaphoresis program (2/85-10/87)	30	0.8%
Orange County, CA	1840	inmate request	50	2.7
Sacramento County, CA	123	inmate request	7	5.7
San Bernardino County, CA	500	voluntary	9	1.8
Santa Clara County, CA	348	women – voluntary	6	1.7
Wisconsin	2125	voluntary	19	0.9

---

[a] Unless otherwise noted, all data are current as of October 1987.

strongly believed to have become infected while in prison. Maryland officials point out that these data suggest very low transmission rates in their system. Moreover, these seroconversions occurred before the implementation of intensive educational programs on AIDS which are believed to have influenced inmate behavior. Maryland has also conducted follow up testing of the original intake cohort used to estimate incoming seroprevalence. Over 300 inmates were followed for one year, and 200 inmates for two years; less than one-half of 1 percent per year have seroconverted. This translates into a possible sixty new infections per year in the entire inmate population, a not insignificant figure, but one far lower than the estimated 300 infections among entering inmates each year. As a result, the Chief Medical Officer of the Maryland Division of Correction asserts that HIV infection "is more of an imported problem than one being developed in prison."[12]

New York state recently analyzed the periods of continuous incarceration of all of its correctional inmates with AIDS. The analysis revealed that none of the inmates had been continuously incarcerated for more than seven years prior to their diagnosis, and only five inmates (2.3%) had been continuously incarcerated for five to seven years prior to their diagnosis. A similar analysis of Florida inmate AIDS cases also revealed that only 2 percent had been continuously incarcerated for seven years or more prior to diagnosis. The rest had all been in prison two years or less.[13]

These figures suggest quite low rates of HIV transmission in correctional facilities. However, as the New York report notes, "the long incubation period, the existence of the asymptomatic HIV carrier state, small number of long-term inmates and absence of data on antibody status make this finding inconclusive."[14] In addition, there are significant variations across jurisdictions in the prevalence of infection and variations in the prevalence of high-risk behaviors in correctional facilities. Both of these variables would effect transmission rates. A recently-initiated CDC-sponsored study of Illinois inmates and a study planned in New York should begin to provide more systematic information on these issues.

Meanwhile, the debate continues over the extent to which HIV infection is being transmitted in correctional institutions. On one side of the debate, correctional administrators point to the paucity of AIDS cases among long-term inmates and some argue further that AIDS is not being transmitted in prisons because the behaviors primarily associated with transmission (sexual activity and intravenous drug abuse) are effectively controlled in the institutions. Questionnaire respondents are virtually unanimous in the belief that all of their inmates with AIDS brought the infection with them into the institution rather than contracting it after they were incarcerated. These conclusions are based on the fact that the intervals between these inmates entering the system and their diagnoses with AIDS were generally much shorter than most estimates of the disease's incubation period.

On the other hand, some physicians and researchers argue from the following syllogism:

1) HIV infection is transmitted through sexual activity and intravenous drug abuse;
2) There may be a relatively high infection rate among inmates;
3) Some sexual activity and intravenous drug abuse occurs in even the best-managed correctional institutions; therefore
4) It is highly likely that HIV infection is being transmitted in correctional institutions.[15]

There are a number of factors regarding prison life that should be considered in attempting to assess the potential extent and primary means of transmission:

- Known outbreaks of syphilis and other sexually-transmitted diseases in prison populations suggest that HIV can also be transmitted in the correctional setting.
- In two studies, the annual seroconversion rates for Hepatitis-B in correctional facilities were found to be about 1 percent.[16] Bearing in mind that Hepatitis-B is easier to transmit than HIV infection, these figures may help to suggest how much transmission of HIV infection is occurring in correctional institutions. On the other hand, seroconversion rates for Hepatitis-B may underestimate the extent of behavior through which the virus is transmitted (e.g., sexual activity and intravenous drug abuse), since there appear to be high rates of immunity to Hepatitis-B among prisoners. Thus, they may be engaging in such behaviors without seroconverting.
- Many (in some jurisdictions, most) inmates have histories of intravenous drug abuse. While it is unclear how much drug abuse involving needle-sharing occurs in prison (and some observers believe that drug use not involving needles is much more common), it is probably inevitable that at least some takes place.
- Reportedly, tattooing and the use of tattoo machines are prevalent in many correctional facilities, and this activity may expose inmates to blood contaminated with the AIDS virus.
- The prevalence of all types of sexual activity may vary widely across correctional systems. A study of New York City jail inmates found that 10 percent of all gonococcal infections (gonorrhea cases) diagnosed between October and December 1986 were acquired while the inmate was in the correctional facility. The study used gonorrhea as a surrogate for homosexual activity. Since the normal incubation period is two-six days, any inmate diagnosed with a new case of gonorrhea *more than one week* after intake was considered to have become infected while incarcerated.[17] A study of Tennessee inmates based on self reports found that 18 percent had engaged in homosexual activity while incarcerated.[18] Finally, a report by the Federal Bureau of Prisons (based on data from the federal system and from some state systems) estimates that 28 percent of inmates engaged in homosexual activity while in prison.[19] It should be noted this estimate is based on anecdotal evidence collected before AIDS became a serious problem in the United States. Since then, AIDS-related educational efforts may have reduced the incidence of homosexual activity in correctional facilities.
- Of particular concern with regard to the question of HIV transmission in prison is the extent to which inmate sexual activity is coerced. According to the Federal Bureau of Prisons report, perhaps 9 to 20 percent of prison inmates (particularly new inmates and openly homosexual inmates) are targets of aggressive sex acts during their incarceration. However, in the federal system, less than 1 percent were found to have been actually victimized.[20] Other observers believe rape and sexual assault are very prevalent and very underreported in correctional facilities.[21]

Prison sexuality is complex; it probably includes consensual, quasi-consensual (i.e., submission based on initial and ongoing intimidation or submission in return for protection, extra commissary items, or other favors), and non-consensual activity. Prostitution and pimping also exist in inmate populations. Some argue that truly consensual sexual activity does not exist in prisons and jails. Only 8 percent of NIJ survey respondents stating an opinion believed that it is possible to distinguish clearly between consensual and non-consensual sex in correctional facilities, while 50 percent felt that the distinction is "somewhat unclear." The various components of sexual activity require very different responses, insofar as the prevention of HIV infection and AIDS is concerned. Consensual activity may be addressed through educational programs (and there are indications that behavioral change is occurring in prisons, perhaps as a result of educational efforts). On the other hand, it may only be possible to reduce quasi-consensual and non-consensual activity by more careful inmate classification, more intensive supervision or surveillance, and more effective prosecution of inmate rapists. For example, some systems seek to identify both aggressive and vulnerable inmates and house them in separate units. Inmates particularly susceptible to victimization may also be placed in protective custody. A critical element of all correctional systems' policies must be the prevention of rapes and other non-consensual sexual activity through which HIV infection may be transmitted to victims.

As noted above, there are currently no conclusive data on the extent of transmission of HIV infection within correctional facilities. However, logic and common sense both suggest that, even in the best-managed correctional institutions, there may be at least some transmission of the AIDS virus occurring among inmates. The question for correctional administrators is what policies are most likely to minimize transmission, while maintaining the essential rights of inmates.

Notes

1. Unless otherwise noted, all figures on AIDS in the American population are from CDC, "AIDS Weekly Surveillance Report – United States," December 28, 1987.

2. Unless otherwise noted, all figures on AIDS in Canada are from "Update: AIDS in Canada," (Ottawa, Federal Centre for AIDS), November 2, 1987.

3. W.M. Morgan, et al., "AIDS: Current and Future Trends," *Public Health Reports* 1986; 101:459-465; Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care, and Research* (Washington, D.C., 1986), pp. 69-70.

4. Centers for Disease Control, unpublished data.

5. Survey responses and CDC, "AIDS Weekly Surveillance Reports," November 4, 1985; October 6, 1986; October 5, 1987.

6. The incidence rate per 100,000 population is a standard measure used to facilitate comparisons. The incidence rates for the population at large were calculated as follows:

$$\text{Incidence Rate} = \frac{\text{Total number of cases reported to CDC in 1987} \times 100{,}000}{\text{Total population}}$$

7. The incidence rates for correctional inmates were calculated as follows:

$$\text{Incidence Rate} = \frac{\text{Current AIDS cases in system} \times 100{,}000}{\text{Current inmate population of system}}$$

The reported number of *current* AIDS cases may slightly underestimate the total number of cases reported during 1987, but most correctional systems do not keep statistics on cases by year reported. Using the current number may slightly underestimate the real annual incidence rate in a correctional system.

8. Bureau of Communicable Disease Control, New York State Department of Health, *AIDS Surveillance Monthly Update*: September, 1987, p. 21, 23.

9. New York State Commission of Correction, *Acquired Immune Deficiency Syndrome: A Demographic Profile of New York State Inmate Mortalities, 1981-1986* (Albany, Update: September, 1987).

10. Ford Brewer, M.D., Maryland Division of Correction and B. Frank Polk, M.D., Johns Hopkins University, Personal Communication.

11. Kelley, P.W., Redfield, R.R. et al., "Prevalence and Incidence of HTLV-III in a Prison" (letter), *Journal of the American Medical Association*, October 24, 1986; 256:2198-2199.

12. Maryland Division of Corrections, "Results of Surveillance for Serologic Evidence of Infection with HTLV-III/LAV in Inmates," presented at Press Conference, Baltimore, December 19, 1985; Ford Brewer, M.D., Maryland Division of Correction, and B. Frank Polk, M.D., Johns Hopkins University, Personal Communication.

13. Harry I. Shuman, M.D., Florida Department of Corrections, Presentation at Florida Department of Law Enforcement Executive Institute Symposium on AIDS, Orlando, December 9, 1987.

14. Bureau of Communicable Disease Control, New York State Department of Health, *AIDS Surveillance Monthly Update*, August 1986, pp. 3-5.

15. See, e.g., M.A.R. Kleiman, and R.W. Mockler, "AIDS, The Criminal Justice System, and Civil Liberties," *Governance: Harvard Journal of Public Policy*, Summer-Fall, 1987:48-54.

16. These studies discovered seroconversion rates of 0.8 percent and 1.32 percent. H.F. Hull et al., "Incidence of Hepatitis-B in the Penitentiary of New Mexico," *American Journal of Public Health* 1985; 75:1213-1214; M.D. Decker et al., "The Incidence of Hepatitis-B in Tennessee Prisoners," *Journal of Infectious Diseases* 1985; 152:213-217.

17. K. Van Hoeven, W.C. Rooney, and S.C. Joseph, "Evidence for Gonococcal Transmission within a Correctional Facility" (unpublished paper, New York City Department of Health, June 1987).

18. M.D. Decker, et al., "Seroepidemiology of Hepatitis-B in Tennessee Prisoners," *Journal of Infectious Diseases* 1984; 150:450-460.

19. P. Nacci and T. Kane, *Sex and Sexual Aggression in Federal Prisons* (Washington, Federal Bureau of Prisons, 1982), pp. 7-9.

20. Nacci and Kane, *Sex and Sexual Aggression*, p. 11.

21. See, e.g., T. Cahill, "Rape Behind Bars," *The Progressive*, November 1985, p. 32-34.

Part Two

Policy Options for Correctional Administrators

Part Two of this report covers the following major areas of correctional policy on AIDS: education and training; HIV antibody screening and testing; medical, psycho-social, and correctional management issues; and confidentiality, legal, and labor relations issues. There is substantial debate in many of these areas. The report presents the rationales advanced for various policies as well as the results of the NIJ survey on the prevalence of the major options identified.

Four major issues affect almost all aspects of correctional decisionmaking regarding AIDS.

1. The importance of effective education and training for both staff and inmates.
2. The relative importance of medical and correctional considerations in policy decisions.
3. The extent and nature of the correctional system's responsibility for preventing the transmission of HIV infection within its institutions.
4. The inter-relatedness of many key AIDS-related policy decisions.

To address the first issue, correctional administrators must develop a clear understanding of the concerns—both rational and irrational—of their inmates and staffs regarding AIDS. Once they have this understanding, they can develop educational programs that address those concerns and that offer practical means for preventing the spread of HIV infection in correctional institutions.

To address the second issue, correctional administrators must decide whether to consider AIDS purely as a medical problem and frame all their policies regarding screening, testing, housing, medical care, and precautionary measures based on medical knowledge and advice, or whether (and how much) they should also take into account the special circumstances of the correctional environment. These circumstances include the potential concentration of persons with risk factors in the correctional population, the need to maintain the personal safety of the inmates and staff, and the need to maintain the security and order of the institutions. Correctional considerations might suggest mass screening of inmates for antibodies to HIV or administrative segregation of inmates with AIDS and ARC, even if medical authorities do not generally recommend such policies for the population at large.

To address the third issue, decisionmakers must determine how much legal and ethical responsibility correctional systems should bear for preventing transmission of HIV infection and whether their responsibilities should be more extensive in any way than those borne by other institutions such as hospitals and schools. In particular, the question arises whether correctional systems are responsible (and perhaps legally liable) for transmission of HIV resulting from consensual acts, or only for transmission resulting from coerced acts. The answers to such questions will determine, first, what procedures and precautions should be undertaken to prevent the spread of the AIDS virus in correctional institutions and, second, what notifications, if any, should be made to correctional staff, previous and subsequent institutions, public health agencies, parole officials, families, and sexual partners regarding inmates with AIDS, ARC, or asymptomatic HIV infection.

To address the fourth issue, correctional administrators should think of their AIDS policy in "big-picture" terms. That is, before deciding to undertake mass screening, they must decide how the test results will be used to achieve the only legitimate purpose of screening—reduction of HIV transmission. Moreover, screening decisions may drive other decisions. For example, should HIV-infected inmates be segregated? Do correctional officers have a right to know which inmates are infected with HIV? A policy decision to screen all inmates for antibodies to HIV may have a major, and perhaps deciding, effect on housing and notification policies. Mass screening without some form of segregation or separation of seropositives whose behaviors indicate that they may pose a risk of infecting others seems to be an ineffective policy combination. Failing to separate these seropositives would seem to forfeit whatever possibility that mass screening will reduce transmission of HIV.

As discussed in Chapter Four, there is serious controversy about the effectiveness of screening in reducing transmission of HIV. But without segregation or separation of seropositives, screening can have little or no effect on transmission. Therefore, correctional systems should probably think in terms of deciding between two basic constellations of policies:

1. mass screening, segregation of seropositives who pose behavioral risks, notification to correctional staff, and education on AIDS; or
2. focusing prevention efforts on mandatory AIDS education and intensive efforts to identify and control predatory inmates and those engaging in high-risk behavior

(without mass HIV screening), together with strict confidentiality of medical information.

Expected seropositive rates and the availability of various types of housing (e.g., single- v. double-cells) will play an important role in these interrelated policy decisions. Ultimately, however, these large policy decisions must be grounded in careful consideration of the advantages and disadvantages of the major options.

Most correctional systems have now adopted AIDS policies. (Examples of comprehensive correctional AIDS policies are included in Appendix G.) Intense political pressure for certain policies — especially mass screening — has been focussed on correctional systems in the last year. The challenge for the future is to resist short-term political pressure and to ensure that the refinement and implementation of policies are based on considered judgment and rational response to the risks posed by AIDS in the correctional setting. This report is designed to help correctional administrators meet that challenge.

Chapter 3: Education and Training

Education and training programs represent the keystone of efforts to prevent transmission of HIV infection in prisons and jails, as well as in the population at large. In fact, the actual and potential role of education affects decisions on virtually all of the other issues and policy options discussed in this report. For example, the effectiveness of educational programs may play a major role in deciding whether inmates with AIDS, ARC, or asymptomatic HIV infection should be segregated.

Overview of the Issues and NIJ Survey Results

Most correctional administrators feel strongly that education and training are not options but absolute requirements. Indeed, virtually all jurisdictions responding to the third annual NIJ survey currently offer or are developing some AIDS training or educational material for staff (97 percent) and inmates (96 percent). All federal/state systems in the United States are providing staff and inmate education programs. All Canadian systems provide education for staff and all but one also do so for inmates. Figures 3.1 and 3.2 show the number and percentage of responding correctional systems using the major modes of AIDS training for staff and inmates—live training, audio-visual programs, and distribution of written materials—as of the first NIJ survey in 1985 and the third annual survey in 1987. The increase in AIDS educational efforts across the board is striking. The increases in the proportion of systems providing live training are most notable since, as will be discussed below, this is the most important, but also the most costly, mode of training.

It is probably more difficult for jail systems to provide inmate training because of the high turnover rates in those institutions. In previous NIJ surveys, fewer jail systems were providing inmate AIDS education (73 percent in 1985). It is noteworthy that inmate education is now provided in almost all jail systems. However, as Figure 3.2 shows, they are still somewhat behind federal/state systems in providing live inmate training (88 percent to 67 percent). Education and training may be more important where turnover is high, because each inmate may come into contact with many other individuals in a relatively short period of time. Moreover, inmate training on AIDS serves important public health objectives, particularly where turnover is high and individuals quickly return to the greater society. Regardless of turnover rates, however, training of inmates also serves important correctional management purposes such as promoting institutional security, reducing medical care costs, and limiting potential legal liability. To this effect, the Massachusetts Sheriffs' Association Task Force on AIDS in County Correctional Facilities has recommended AIDS education for staff and inmates in all Massachusetts county jails.[1] The New York City and San Francisco jail systems have also developed extensive AIDS education programs for inmates.

Education and training are particularly necessary because of the prevalence of misinformation on AIDS. While there may finally be less fear among inmates and staff that HIV is transmissable by truly "casual" contact, there is still widespread misunderstanding of the ways in which the virus is actually transmitted. More than one-half of responding correctional systems noted that staff concern regarding AIDS had increased in the past year, while 34 percent reported stable levels of concern and only 8 percent said that concern among staff had declined.

Staff perceive their contact with inmates to be more than "casual" and therefore still worry about being infected on the job. Correctional officers are especially concerned about being infected when aggressive inmates bite them, spit in their faces, throw urine or feces on them, or jab them with sharp instruments. Such incidents are not uncommon in correctional facilities. Staff are also concerned about the risks involved in breaking up fights among inmates and providing CPR and other first aid to inmates. Correctional staff are most troubled by the thought that they could contract HIV infection and transmit it to their families. Some of the specific incidents of concern to correctional staff—such as biting, spitting, and urine-throwing incidents—have not been associated with even a single case of HIV infection. Others, such as needlesticks and blood-to-open-wound/mucous membrane contact, in fact *have* resulted in infections, but only to tiny fractions (well under 1 percent) of persons documented to have experienced such exposures (see Chapter One).

Concerns about exposure to HIV have led staff in some jurisdictions to refuse to work in medical or non-medical units housing inmates with AIDS or ARC, to demand that all inmates be tested for antibody to HIV, and to call for restrictions on the work assignments of inmates (e.g., no food service assignments) in all three AIDS-related categories. In some jurisdictions,

Figure 3.1

MODES OF AIDS TRAINING PRESENTATION FOR STAFF

Modes of Presentation[a]	State/Federal Prison Systems				City/County Jail Systems				Canadian Systems	
	First Survey: November 1985		Third Survey: October 1987		First Survey: November 1985		Third Survey: October 1987		October 1987	
	(n = 51)		(n = 51)		(n = 33)		(n = 33)		(n = 12)	
	n	%	n	%	n	%	n	%	n	%
• Live Training	19	37%	51	100%	10	30%	29	88%	11	92%
• Audio-visual Programs	17	33	50	98	12	36	25	76	10	83
• Written Materials	26	51	45	88	18	55	18	55	9	75

---

[a] Includes programs in operation and under development.

Figure 3.2

MODES OF AIDS TRAINING PRESENTATION FOR INMATES

Modes of Presentation[a]	State/Federal Prison Systems				City/County Jail Systems				Canadian Systems	
	First Survey: November 1985		Third Survey: October 1987		First Survey: November 1985		Third Survey: October 1987		October 1987	
	(n = 51)		(n = 51)		(n = 33)		(n = 33)		(n = 12)	
	n	%	n	%	n	%	n	%	n	%
• Live Training	16	31%	48	94%	8	24%	22	67%	9	75%
• Audio-visual Programs	14	28	50	98	10	30	22	67	9	75
• Written Materials	28	55	50	98	15	45	28	85	10	83

---

[a] Includes programs in operation and under development.

correctional officers' unions have filed grievances and threatened strikes over the AIDS issue. Other reactions include staff calls for reduced working hours and hazardous duty pay. (See Chapter Six for a discussion of labor relations issues.)

Of the correctional systems responding to the NIJ questionnaire, 40 percent reported that inmate concern about AIDS had increased since 1986, and 47 percent said that levels of inmate concern had remained the same; only 9 percent reported declining levels of concern. Some inmates have reacted to the problem by demanding HIV antibody testing of all inmates, refusing to take work assignments involving contact with HIV-infected inmates or their belongings (e.g., as hospital porters or laundry workers), demanding that seropositive inmates or homosexual inmates be excluded from food service assignments, and calling for segregation of all high-risk inmates. New York state prisons have encountered some resistance from inmates to being housed in cells just vacated by persons suspected of having AIDS. There have also been instances of threats and actual violence against inmates with AIDS, ARC, or asymptomatic HIV infection. A female inmate in Massachusetts notes that the fear of AIDS has driven inmates apart and increased tensions in the institution.[2]

Such reactions among staff and inmates reflect serious misunderstanding of the documented means of AIDS transmission. Education and training programs may be able to counteract misinformation and rumors by carefully marshalling accurate information.

Effects of Education and Training on Inmates and Staff

NIJ survey results show that inmates' concern about AIDS is not decreasing in most correctional systems. However, inmates in many correctional facilities show a growing receptiveness to AIDS education. In the past, inmates who attended AIDS classes were often stigmatized as gay by their peers. Now, inmate interest in the topic is broader and more apparent. In December 1987, 200 of the 544 inmates (more than 40 percent) at a New York state maximum security facility signed up for voluntary AIDS education. Indeed, in some jurisdictions, the inmates are more receptive than staff to AIDS training and education. However, some correctional systems still encounter problems with inmates hesitating to ask questions for fear of being labelled as a member of a risk group. This underscores the importance of trainers making themselves available for questions after training sessions. Or, in the interest of inmate anonymity, trainers might ask inmates to submit their questions in writing, which the trainer can answer without reference to individuals.

Still, opinions differ on the effectiveness of AIDS education. While New York state officials report that homosexuality among inmates has become more monogamous, some other jurisdictions report that high-risk behavior, especially needle-sharing, has increased in spite of education. Such systems request increased drug-treatment capability and improved training on IV drug use-associated AIDS. Some systems perceive intravenous drug use and homosexuality among inmates to be as prevalent now as they were before the AIDS problem. An official in one correctional facility notes that "guys with long sentences don't care" enough about the risk of transmission to change their risky behavior.

Despite these mixed reviews on the effectiveness of inmate AIDS education, systems must persist in their efforts to provide this critical information. There is evidence from the world outside correctional facilities that gay men and even IV drug users are reducing or eliminating high-risk behaviors out of concern about AIDS.[3]

As noted above, concern about AIDS among correctional staff has not markedly declined in most jurisdictions. However, examples of successful staff training and education efforts abound. Several years ago in New York City, a threatened walkout by correctional officers over the presence of inmates with AIDS was averted by a carefully designed education program. In fact, New York City correctional officials believe that their training program has "put the AIDS hysteria to rest."

In New Jersey, timely educational efforts also prevented a threatened job action by the correctional officers' union and led staff to reverse an earlier refusal to transport inmates with AIDS. In another state, a union grievance was filed demanding that inmates be tested for antibodies to HIV before they could be assigned to work in food service. This dispute was also satisfactorily resolved through educational efforts without instituting a testing program. Arizona reports that correctional institutions with the most intensive training and education programs have the fewest problems with acceptance of inmates with AIDS, ARC, and asymptomatic HIV infection. Texas also reports that there have been no major conflicts regarding the presence of inmates with AIDS and ARC in prison units where education and training were provided on a timely basis.

At New York state's Sing Sing prison, there are now more applicants than positions for staff on the facility's AIDS unit. This is evidence that AIDS education there has helped change staff attitudes towards dealing with infected inmates. A similar attitude prevails at the Vacaville, California facility, where there are also more applicants than positions for staff on the AIDS unit. Correctional officers there take pride in being educated professionals who understand the extremely low risk of becoming infected on the job.

While this reported experience is encouraging, it is still important to point out that the effectiveness of training and education depends on programs being planned and developed with sensitivity to both the rational and irrational fears of all affected groups. A poorly designed education program may simply draw attention to the problem without allaying the concerns of staff and inmates.

Although the vast majority of correctional administrators agree that it is important to provide education on AIDS for staff and inmates, there are a few who believe that these programs may be counterproductive. In one California county, for example, policymakers resisted instituting inmate education on AIDS because they believe it "would most likely cause panic." Similarly, the superintendent of a New York facility explains that no live training is provided for *inmates* because it might inflame their fears and increase hostilities. Several other respondents note that staff educational programs on AIDS may be ineffective because correctional officers are suspicious of any information coming from government agencies. Still, available evidence overwhelmingly supports the importance and potential effectiveness of education and training on AIDS for staff and inmates.

High-quality AIDS training and education are expensive. But the investment is worthwhile. A well-educated staff is more efficient and a well-educated inmate population is less likely to be disruptive when AIDS-related issues arise. In addition, inmate training, if it can prevent HIV transmission, may ultimately save the system the costs of caring for inmates with AIDS. The key elements of training and education programs for correctional inmates and staff are discussed below.

Key Elements of Education and Training Programs for Inmates and Staff

Most correctional systems provide staff and inmates with some general training or informational materials on AIDS and the means of transmission of HIV. In addition, staff and inmates may both receive more specialized training and information: staff training usually emphasizes ways to reduce risk during contact with inmates, while inmate training typically stresses avoiding behaviors such as sexual activities and needle-sharing that may result in transmission of the AIDS virus. (Examples of training curricula for inmates and staff are presented in Appendix D.) While the content of much of the general information on AIDS presented to staff and inmates is usually very similar, training sessions for the two groups are always conducted separately. Individual counseling of persons before and after HIV antibody testing and for persons found to be infected is also an important part of an AIDS education program. This counseling is discussed in Chapter Five.

Timely Education and Training

Experience suggests that it is important to plan and institute educational programs on AIDS as early as possible – preferably before the first case is identified or before serious concerns surface among inmates or staff. Some physicians suggest that fear concerning transmission of HIV is greatest where there is the least actual experience with AIDS cases. Ideally, AIDS training and education for staff should be provided before staff develop unsubstantiated fears regarding the disease. Instruction on AIDS should be included in both staff recruit training and inmate orientation. Survey results reveal that 82 percent of state and federal systems, but only 52 percent of responding city and county systems and 50 percent of Canadian systems, provide (or are developing) live training programs on AIDS as part of the initial training of new employees.

Sixty-nine percent of federal and state systems, but only 24 percent of responding city and county systems and 33 percent of Canadian systems, provide (or are developing) live training on AIDS to all inmates at intake. Many more systems provide written materials on AIDS to inmates at intake.

Regular Education and Training

Training and education should also be presented to inmates and staff at regular intervals after intake or commencement of employment. Over half of state and federal, city and county, and Canadian systems provide live AIDS training to inmates at various intervals during their incarceration. Three-fourths of state and federal systems, city and county, and Canadian systems provide live in-service training on AIDS to staff.

The frequency with which education is presented depends on the mode of presentation. Pamphlets and brochures may be distributed or made available almost continuously during incarceration or employment. In most cases, live training sessions are only held every few months or as infrequently as every year, depending on the size of the system and the perceived need for training. However, it is important to provide information as regularly as possible. Without frequent doses of accurate information, misinformed fear will quickly reassert itself.

Because of the changing nature of the AIDS situation, it is important to present updates on any new developments and to offer accurate and timely information to counteract unfounded rumors. Over 40 percent of state/federal systems in the United States have expanded and/or updated the content of their inmate AIDS training in the last year, while 39 percent of responding city/county systems and half of the Canadian systems have done so. The equivalent percentages for systems which have updated and/or expanded staff training content in the last year are 45 percent, 35 percent, and 25 percent. These represent significant percentages of correctional systems but, in fact, *all* systems should expand or at least update the content of their AIDS education programs each year.

All correctional systems should assign someone to stay abreast of the latest developments on AIDS and to formulate a quick and appropriate response when necessary, as certain systems have done. For example, in May 1987, the media reported an incomplete and alarming story about three health care workers who became infected with HIV after contact with the blood of infected patients. Many accounts failed to report or emphasize that all three cases involved direct blood-to-blood or blood-to-mucous membrane contact (long known as a means of HIV transmission) and that all three health-care workers had failed to follow recommended infection control procedures when the incidents occurred. The press reports of these health-care worker cases caused great concern among correctional and law enforcement personnel. Many correctional systems responded to the situation immediately. California's correctional department distributed copies of the Centers for Disease Control's *Morbidity and Mortality Weekly Report*, which contained full and factual accounts of the cases, to the correctional officers' union for inclusion in its newsletter. At all Maryland institutions, medical directors presented the facts of the cases at roll call. The Illinois Department of Corrections' medical director sent a memorandum to all their health care workers, in which he summarized the CDC report and clearly laid out the facts. These proactive responses to the media's coverage helped to calm staff members' concerns.

New York State's Department of Correctional Services also takes a proactive stance on AIDS education for staff. The department's Communicable and Infectious Diseases Coordinator holds small, focused training and education sessions at various institutions on request. In the past, these have included a meeting with correctional officers' unions when Sing Sing opened its AIDS unit and crisis management sessions with transportation officers.

AIDS education just prior to inmate release may also be extremely useful. Such sessions provide opportunities to make inmates fully aware of the risks and responsibilities they will face as they return to the community at large, with its broader range of personal freedoms and choices regarding sexual activities, drug abuse and other potentially dangerous behavior. Currently, however, only 16 percent of state and federal systems, 3 percent of responding city and county systems, and no Canadian systems present AIDS training to inmates at the time of release. This is an area with much room for improvement.

Mandatory Education and Training

Because of the importance and relevance of AIDS to correctional systems and because of the prevalence of unreasonable fears and unfounded views regarding transmission of HIV, all agencies should make staff and inmate training mandatory.

In response to the widespread concern about AIDS, some correctional systems have instituted mandatory education programs on the subject for inmates and staff. Currently, only 35 percent of state/federal systems, 6 percent of city/county systems, and no Canadian systems make all inmate AIDS training mandatory. However, 71 percent of state/federal systems make at least some inmate training on AIDS mandatory. Staff training on AIDS is always mandatory in 55 percent of state/federal systems, 42 percent of city/county systems, and no Canadian systems. However, at least some staff training is mandatory in 88 percent of state/federal systems, 67 percent of city/county systems, and one-half of Canadian systems.

Current mandatory training generally involves sessions during recruit training and/or in-service education. The California Department of Corrections provided two hours of mandatory AIDS training to all staff (about 25,000 people) between 1986 and 1987. The California correctional system also conducts mandatory training for recruits and a half-hour's mandatory refresher course for correctional staff. Maryland requires AIDS training for all new staff and mandates in-service AIDS sessions. Additionally, the medical director of Maryland's correctional system has done required roll-call sessions on AIDS at all of the state's institutions. Maryland also requires AIDS training at least three times for *each* inmate: at intake, during incarceration, and before release. The correctional department contracted with the Health Education Resources Organization (HERO) to train thirty-six staff members, from line correctional officers to psychologists, to be AIDS educators. They have led both inmate and staff AIDS sessions. Even some jail systems are adopting mandatory training. The Massachusetts Sheriffs' Association recommended that there be mandatory AIDS education for inmates and staff in all county jails in the state.[4]

Mandatory staff training will probably present problems of logistics and increased cost—e.g. the potential need to provide overtime pay or cover the posts or positions of duty staff while they attend training. California spent two million dollars in one year to provide mandatory AIDS training to all staff. However, the importance of the subject warrants the extra effort and cost required to mount such training.

It is particularly important to make staff training mandatory because there are indications that those staff members who are most affected by unsubstantiated fears are also the ones most likely to avoid voluntary training sessions. Some systems discovered that correctional staff, despite expressing great concern about AIDS, showed poor attendance at voluntary training sessions.

Officials sometimes oppose mandatory training on the grounds that unwilling inmate participants will disrupt the sessions. Where such a problem might exist, mandatory sessions of smaller groups or one-to-one sessions may be a possible solution.

Several systems have instituted innovative approaches to maximizing the audience for inmate education on AIDS. In Minnesota, for example, videotaped training segments on AIDS were the only programs available on institutional closed-circuit television during certain time periods. California and other systems plan to use closed circuit television systems to present AIDS education.

Strong Executive and Management Commitment to Education and Training

The most successful AIDS training and education programs thrive because of their managers' commitment to the programs. Correctional managers who endorse AIDS training help maximize trainer credibility and trainee receptiveness. At the Shawangunk (New York) correctional facility, the superintendent or his chief deputy introduce all AIDS training sessions, thereby demonstrating management's commitment to the program. At Sing Sing correctional facility, the executive staff regularly visit the AIDS unit, a practice which has helped to reduce the fear of AIDS among other inmates and staff.

Managers can especially help in easing the logistical problems posed by large-scale training programs. By resolving scheduling problems for staff training, such as by authorizing overtime (if permitted), management can ensure that AIDS education reaches as many staff and inmates as regularly as possible.

Staff and Inmate Participation in Development of Educational Programs

Educational programs should be targeted to the identified concerns and informational needs of staff and inmates. Thus, if possible, correctional systems should involve representatives of the target audiences in the development of AIDS training.

Staff, union, and inmate representatives should participate in the development of training materials and training programs. Their participation can help to counteract suspicions that department management is using the training to "pull the wool over our eyes." Like many citizens, correctional staff have displayed skepticism of the medical community's pronouncements on AIDS. Therefore, training which simply presents medical research as unequivocal fact may not be effective in allaying unsubstantiated fears. Research on correctional systems' response to AIDS has found that some of the most effective training programs are those developed jointly by management, staff members, unions, inmate representatives, medical experts, and health professionals.

Currently, only 26 percent of state/federal systems, 12 percent of responding city/county systems, and 8 percent of Canadian systems give inmates a direct role in the development of AIDS educational programs. By contrast, almost two-thirds of responding systems involve staff in development of training and education programs.

Effective training should be based on systematic information about concerns and knowledge gaps. One way to develop such information is through brief tests of knowledge and perception regarding AIDS. Some states use these as pre- and post-tests during training sessions, but they might be even more effectively employed to inform the *initial* development and ongoing refinement of training programs. (An example of a pre/post test of AIDS knowledge is included in Appendix D.)

Correctional systems have used various methods to involve staff and inmates in the development of AIDS education. In South Carolina, staff took questions commonly posed by correctional officers and based their training on answers to these questions. The New York City Department of Corrections solicited specific questions on AIDS from the entire correctional staff as a first step in developing an extremely effective staff training videotape. The questions received were distilled into ten-twenty key questions. The City's Commissioner of Corrections and Commissioner of Health were then brought together to respond to these questions. The discussion was videotaped and edited into a forty-minute program. Maine's staff unions worked with their Department of Corrections to develop an AIDS training program. Similarly, in Missouri, an AIDS Policy Implementation Committee, composed of staff from many levels and functions, helped to develop the AIDS training curriculum.

Inmate participation in the development of AIDS education programs can also be extremely useful. Oregon has revised its inmate education program based on inmate evaluations. The state is considering using inmate focus groups and inmate resource persons for future program development. In a South Carolina facility, the staff held a joint educational planning session on AIDS with an inmate advisory council.

New York City prepared an inmate videotape from a discussion between the Director of Montefiore Medical Center-Rikers Island Health Services (a unit which provides 85 percent of all medical and mental health care services to inmates of the New York City correctional system) and the heads of eighteen inmate councils from institutions across the city. This was a spontaneous question-and-answer session on AIDS, during which the inmate representatives were able to pose any questions they wished. New York City also employed inmate focus groups in developing other aspects of its AIDS education program. The Correctional Services of Canada has incorporated concerns raised by inmate committees into its AIDS training.

Live Education and Training

Live training on AIDS—lectures, seminars, discussion groups, question-and-answer sessions and other programs involving live trainers—is the most effective format, because it provides staff members and inmates the opportunity to raise their own specific questions and concerns and to receive responses from people who are knowledgeable about the epidemiology and means of transmission of HIV infection and AIDS, and able to answer questions clearly and effectively.

Officials of the New York City Department of Corrections, who have extensive experience dealing with the AIDS problem, argue strongly that passive educational programs (such as printed materials, videotapes, or slide-tape shows) are by themselves not enough. They firmly believe that it is important to have live training sessions with trainers who are knowledgeable about the issues, sensitive to the concerns of all groups, and who are able to answer questions on the spot. New York City does not simply show its videotaped programs to staff and inmates; it supplements the videotapes with live question-and-answer periods.

Eighty-two percent of all responding jurisdictions now provide (or are developing) live training on AIDS to inmates, while 95 percent provide (or are developing) live training for staff. State/federal systems and systems which have experienced more inmate cases of AIDS are most likely to provide live training. Only two-thirds of jurisdictions which report no inmate cases provide live inmate training, as opposed to 100 percent of jurisdictions which have had more than twenty-five cases. These findings point to the need for *timely* live training—that is, training provided in advance of the first active case of AIDS—in an effort to "head off" misinformation and fear.

Jurisdictions providing live training allocate, on average, 55 percent of each inmate session, and 41 percent of each staff session, to questions and answers. It is very important to allow sufficient time for the audience to ask, and receive answers, to its questions. Having insufficient time for questions may defeat the purpose of the training, by sending the audience away frustrated and/or feeling that the correctional system is not willing to address individuals' concerns in a forthright manner.

Variations in mode of presentation exist not only across, but also within correctional systems' training programs. In New York state, there is no absolute requirement for live training. Only distribution of brochures is mandatory in the state; other forms of education are left to the discretion of each institution's superintendent. Rhode Island has found that small group and one-on-one discussions, as alternatives to traditional classroom instruction, are helpful in educating inmates and staff. A workshop format has been used in staff training in several systems. National Capitol Systems, Inc. (NCSI), under contract with the National Institute on Drug Abuse, offered workshops designed to address staff skepticism and perceived powerlessness regarding AIDS. The group exercises involved soliciting potential transmission incidents from staff and walking them through an "anatomy of AIDS transmission risk." In these workshops, leaders dismissed no situation as too farfetched and made no assessment until the group determined a final level of risk. Participants evaluated relative risks and decided which situations presented real risk and which did not, increasing the staff's sense of control. Discussing and assessing specific risk reduction strategies helped participants to develop "a concrete sense of the 'doability' of prevention."[5] NCSI has also developed an "AIDS virus transmission scorecard" to assess particular incidents and behaviors of concern to correctional staff.

AIDS training and education may thus vary with the audience size, training facilities, and perceived audience receptiveness of individual institutions within the same system. Some institutional managers favor live training, while others—anticipating heightened fears or disruption—oppose it. Live training is expensive and may raise troubling issues. However, its advantages strongly outweigh its drawbacks. *All* facilities in all systems should provide live training on AIDS for staff and inmates.

Other Modes of Presentation

Videotapes and Other Audio-Visuals

As noted above, videotapes and other audio-visuals can be useful elements of an AIDS training program. However, they should not be the only element of the program. Eighty-nine percent of responding jurisidictions incorporate videotapes into staff AIDS training, while 84 percent use them in inmate training.

Numerous videotapes and slide-tape presentations are available. The National Institute of Corrections (NIC) prepared a videotape from a CDC presentation on the basic facts regarding AIDS and distributed the tape to all state correctional departments. The American Correctional Association has produced AIDS videotapes for staff and inmates. Individual states and jurisdictions, including New York City, have also made videotapes of their own—showing staff, inmates, and physicians discussing their concerns regarding AIDS. (A listing of available audio-visual materials and ways to obtain them is included in the Resource List in Appendix A.)

Two audio-visual programs deserve special mention. "AIDS — A Bad Way to Die" is a videotape produced by and for correctional inmates. It is an extremely effective presentation, based on extensive interviews with AIDS patients in the New York state correctional system. It shows the effects of AIDS in graphic detail and offers dramatic words of warning from inmates suffering from the disease.[6] Many correctional systems show this videotape as part of their live training sessions and rate it very highly. However, several systems note that the videotape is too long and have edited it down to focus on the inmates' statements, the most affecting part of the presentation.

Several correctional systems have complained of the lack of an effective videotape aimed at women's concerns. "Dying for Love" may fill the need. While not developed expressly for correctional audiences, it addresses all of the major issues of particular concern to women, including negotiation with partners regarding condom use, pregnancy and the risk of transmitting HIV to one's fetus or infant. This videotape has been used to good effect in the San Francisco women's jail.

Other commonly shown videotapes include:

- "Sex, Drugs, and AIDS" (ODN Productions);
- "Beyond Fear" (American Red Cross);
- "AIDS Questions and Answers" (Cermak-Cook County, Chicago);
- "AIDS for Inmates" (Federal Bureau of Prisons); and
- "AIDS for Staff" (Federal Bureau of Prisons).

Many systems use more than one videotape, showing both a locally produced and a national videotape, or perhaps alternating between them.

Canadian correctional systems all use AIDS videotapes for inmates and/or staff. These range from privately made films, such as "AIDS Alert" (Kenetic Industries) to federally produced ones, such as "AIDS" (Correctional Services of Canada).

Written Materials

Over 90 percent of correctional systems furnish written materials on AIDS to inmates, while 75 percent distribute such materials to staff. Like audio-visuals, written materials can be a good supplement to, but should not substitute for, live training.

Brochures and Posters. Most institutions distribute AIDS brochures or information sheets to inmates at intake, during their incarceration, and/or before release. Staff typically receive materials at hiring. Some systems have created their own materials, but many rely at least partly on publications from other sources, such as national, state, or local public health agencies, the American Red Cross, and local AIDS advocacy projects. Good written materials present the facts and precautions regarding transmission, while emphasizing to inmates and staff that "AIDS is hard to get." Currently, specialized brochures on AIDS exist for virtually every kind of audience likely to be in correctional institutions, from intravenous drug abusers to gay men to pregnant women. Spanish-language versions of informational materials and training curricula have been developed in Florida and other jurisdictions.

California is employing yet another innovative medium for AIDS education—posters, designed by and for inmates. In particular, an asymptomatically infected inmate at Vacaville has drawn numerous striking AIDS posters, many of which address specific inmate issues, such as tattooing. The institutions display these and other AIDS prevention posters in various locations, such as living areas, medical units, and staff areas. (Several of these posters are included in Appendix D.) Each of California's correctional institutions has appointed an AIDS materials coordinator to distribute materials and ensure that posters are displayed. California's system also places AIDS information brochures in family visit units.

New York City distributes AIDS information kits to all inmates prior to their release. These kits include brochures, AIDS hotline cards, and condoms. (For examples of well-conceived written materials and posters currently being distributed in correctional facilities, see Appendix D.)

Inmate and Staff Publications. Commonly employed media for education on AIDS include inmate newspapers, staff newsletters, and union publications. In Connecticut, Illinois, and other jurisdictions, correctional medical directors have solicited inmates' questions on AIDS and published written responses in inmate newspapers. These questions and answers cover basic information on AIDS and present practical guidance for preventing transmission of the AIDS virus within the institution.

> *From Questions and Answers on AIDS in an Illinois inmate newspaper*
>
> (answers prepared by the state's correctional medical director):[7]
>
> *Question*:
>
> What can inmates do to eliminate the possibility of getting AIDS?
>
> *Answer*:
>
> The only way to eliminate the possibility of getting AIDS . . . is [to] . . . avoid sexual contact with other inmates and . . . sharing needles [drug *or* tattooing] with other inmates. If inmates avoid these two things, it is virtually impossible for them to get AIDS.

Simple and Straightforward Messages

Regardless of the medium, experience suggests that all materials and presentations be in clear, simple, layperson's language which inmates and staff will understand. Inmate materials should assume a low level of literacy and, therefore, avoid technical language. Where terms such as "condoms" and "needles" (syringes) are used, they should also be defined in popular jargon, that is, "rubbers" and "works".

Experience suggests that presentations be kept brief, but there should be flexibility depending on the level of interest shown by the audiences. Maryland usually limits inmate live training sessions to thirty minutes in order to keep them manageable and to allow ample opportunity for inmates to ask questions. Most staff training sessions appear to be about one hour long.

All educational programs should emphasize key practical advice, rather than present complex discussions of the epidemiology of AIDS. Question-and-answer formats like those discussed earlier can be very effective if they are based on a relatively small number of key questions—e.g., "How is HIV transmitted?", "Can I become infected with HIV through casual contact with another person?", and "What can I do to avoid HIV infection in the correctional institution?"

Credibility

Correctional administrators stress that perhaps the most important quality of a successful training and education program on AIDS is credibility. Without credibility, a training program may be worse than useless. All information presented should be straightforward and honest. Any misrepresentation of the truth may totally undermine the effectiveness of an educational program. To overcome skepticism that inmates and staff are being given different stories on AIDS, several correctional systems, including New Jersey's, have staff representatives attend inmate training sessions and inmate representatives attend staff sessions.

One state encountered suspicion from some of its correctional officers that training and issuance of gloves were merely correctional department ploys to avoid liability should a staff member become infected with the virus. This type of skepticism can be eased if management is consistently accurate and clear about the facts. Withholding information—for example, evidence that open-wound and mucous membrane contact *can* lead to infection—may backfire when people obtain the correct information elsewhere. Given the tensions that already exist in a correctional setting, credibility must be maintained through consistency and open communication.

Knowledgeable and Approachable Trainers and Presenters

Sixty-nine percent of state/federal systems, but only 30 percent of responding city/county systems and 42 percent of Canadian systems, use medical experts in inmate AIDS training, whereas at least 70 percent of all types of correctional systems use such experts for staff training. Credibility is very important for both audiences, so knowledgeable trainers should be used for both inmate and staff sessions. It is extremely helpful to have a physician present, at least during part of the session, to answer medical questions.

In general, trainers who establish a good rapport with their audience are more likely to make an impact with their instruction. In site visits to the San Francisco County Jail and the Maryland Correctional Institution for Women at Jessup, we observed trainers who immediately established a rapport with women inmate audiences and received plentiful and candid questions from the inmates. Methods of establishing rapport will vary with audience and institution. However, it may be helpful for trainers to call on inmates or staff by name, pace the session for each audience, speak the audience's language, and generally be trustworthy and approachable. All questions should be answered directly, clearly, and completely.

Outside speakers – for example, from the public health department or from the private sector – may sometimes be more credible to inmates and staff than presenters from the correctional department. Of course, this will depend on history and attitudes in each correctional institution. Correctional administrators should consider all of these factors about trainers and presenters as they plan and develop their own training programs.

Standardized Programs

Standardizing AIDS education and training programs is a form of quality control which may help develop credibility. In New York State, considerable variation in training exists across institutions. However, the correctional department is working with the Department of Health's AIDS Institute to maximize the consistency of the training provided. Institute staff travel to correctional facilities at the request of the superintendent and conduct training for staff in the morning and inmates in the afternoon. The sessions are virtually identical. This way, the Institute avoids presenting contradictory information that could undermine credibility. The Correctional Services of Canada is currently developing a standard AIDS curriculum for all of Canada.

Materials Prepared by National Organizations

While many jurisdictions have prepared their own training materials, several state administrators believe that materials prepared by national organizations may be more credible than locally prepared materials. They feel that the correctional department may be perceived as having "an axe to grind" or something to hide, whereas a national organization may be viewed as more objective in its approach to the problem. Again, these decisions must be based on a careful assessment of attitudes in each correctional system. About one-half of responding correctional systems rely entirely on written materials for inmates developed by others, while about one-third depend on outside written materials for staff.

Use of Training Teams and Peer Trainers

Involving inmates in the delivery of inmate training and staff in the presentation of staff training may improve the program's credibility and trainers' rapport with their audiences. However, relatively few systems use staff representatives to present training (41 percent in state/federal systems, 36 percent in responding city/county systems, and 33 percent in Canadian systems) and very few use inmate representatives (2 percent in state/federal systems, 3 percent in city/county systems, and 8 percent in Canadian systems). Correctional administrators may wish to consider this training option.

A few correctional systems presently use inmates with good results, to present formal training. At the California Correctional Medical Facility at Vacaville (a reception, medical, and pre-release center which houses all of the California Department of Corrections' inmates with AIDS, ARC, and asymptomatic HIV infection), plans are underway to set up an AIDS Information Center, complete with an inmate-staffed hotline (on the internal telephone system). Moreover, at Vacaville, two inmates – one with asymptomatic HIV infection and one with full-blown AIDS – assist with the training of other inmates in the medical, pre-release, and reception components of the facility. These inmates present a personal perspective on AIDS – e.g., how I became infected and how it feels – which injects credibility and realism into the program. Their participation also serves as important therapy for the two inmate trainers themselves. One of these inmates commented, "At first, [participating in the training] was just a way to get away from the unit. Now, I'm really committed to it. It can really make a difference. It's all I have to live for." The other inmate participates in live training sessions and designs AIDS prevention posters which are prominently placed around the facility. Inmate trainers report that, after initial suspicion, their audience responded very positively to peer training, ending sessions with handshakes, hugs, and other expressions of empathy and gratitude for the peer trainers.

Even if inmates are not used in formal training, they may be effectively involved in informal educational efforts. For example, New York state's correctional officials deliberately sought to meet with inmate group leaders and provide them with information on AIDS which they could convey to their group members.

A word of caution regarding the use of inmates in any AIDS education efforts: to avoid undermining the credibility of the whole program, the peer trainers must be knowledgeable and present consistent information.

Correctional systems may wish to consider training teams. These may be more effective than single trainers in presenting AIDS educational sessions, because of the range of issues and questions that may arise and the need to maintain credibility for all groups. Training teams for both inmates and staff should include knowledgeable medical professionals, because laypersons are less credible in responding to technical medical questions that are likely to arise. In addition, inmate training teams should include an inmate spokesperson, and staff training teams should include a staff member. These representatives can respond to more practical issues and provide assurance that the training program is a cooperative effort to present accurate, fair, and reasonable approaches to the problem rather than an attempt by the system to mislead inmates or staff. Several states and jurisdictions have had success using such training teams to present AIDS educational sessions.

Avoiding Extremes of Alarmism and Complacency

Staff and inmate education programs on AIDS must carefully avoid extremes of both alarmism and complacency. An alarmist tone may evoke undue fear, while a complacent tone may fail to encourage the appropriate level of care and caution. The plain facts are that a few well-defined types of exposures and behaviors must be of concern to everyone and that this concern should affect relationships with everyone. In short, "AIDS is not a disease of high-risk groups, but of high-risk behaviors." However, far too many people take the converse—and potentially very dangerous—position that the AIDS virus may be transmitted by many types of contact—including casual contact—but that the only persons to be concerned about are members of "high-risk" groups.

It may be alarmist to require or recommend that staff wear gloves, gowns, and masks for all contact with persons known or suspected to be infected with the AIDS virus, or persons thought to be in AIDS "high-risk" groups. Such precautions are not normally necessary unless contact with blood or body fluids is likely to occur. Requirements that protective clothing be worn for all contacts may encourage the incorrect view that HIV can be transmitted by casual contact.

On the other hand, statements which complacently suggest that risk is limited to certain groups may seriously undermine the critical educational message that everyone must be careful about certain behaviors and exposures. While unsubstantiated fear is counterproductive, concern and caution are essential for all. Correctional staff and inmates must adopt "universal precautions". That is, they must avoid unprotected contact with the blood or body fluids of anyone—whether or not they say they have AIDS, appear to be ill, or seem to be in an AIDS "high-risk" group. If the tone of AIDS training programs is not properly balanced between caution and reassurance, these programs may encourage misinformed beliefs which could adversely affect the security of correctional facilities.

Training Keyed to Specific Concerns of Correctional Audiences

After presenting some basic medical information on the disease, training programs on AIDS should be related specifically to correctional situations. Specific content will, of course, depend on the specific duties and concerns of the audience, but strictly generic materials are insufficient. Key educational and action messages that ought to be conveyed in regard to some of the specific concerns of correctional audiences are summarized in Figure 3.3. Topics covered in the training should be relevant to the situation of the audience. For example, if alternative test sites are not available to inmates, the trainer should not discuss them.

Several jurisdictions, including New York state, have developed their own question-and-answer brochures specifically for correctional officers. New York's is based on "questions about AIDS asked most often by employees of the . . . Department of Correctional Services."[8] Other jurisdictions have tailored generic AIDS brochures produced by public health agencies to correctional audiences. Question-and-answer segments have been added, deleted, or rephrased to make the material more relevant to the correctional setting. For example, an additional question might be: "Can I catch AIDS if I share a cell with a person who has AIDS?" In many of these brochures the language has been simplified, and preventive measures have been described in colloquial terms more readily understandable to correctional audiences.

Staff training and education can address the increasingly prevalent problem of inmates using AIDS as a threat. For example, an inmate might say to an officer, "I have AIDS, and I'll spit at you if you don't ______ ." In such situations, the educated correctional officer will know that he has nothing to fear, since spitting poses a negligible risk in transmitting HIV. Education can thus "unload the gun" of inmate threats.

Figure 3.3

APPROPRIATE EDUCATIONAL AND ACTION MESSAGES TO ADDRESS AIDS-RELATED CONCERNS OF CORRECTIONAL PERSONNEL

Issue/Concern	Educational and Action Messages
Human Bites	Person who bites is typically the one who gets the blood; viral transmission through saliva is highly unlikely. If bitten by anyone, milk wound (like a snake bite) to make it bleed, wash the area thoroughly and seek medical attention.
Spitting/Urine	HIV isolated only in very low concentrations in saliva and urine; transmission through saliva or urine is highly unlikely. Estimated to require 1 quart of saliva or urine entering the bloodstream. No cases of HIV infection or AIDS associated with saliva or urine.
Feces	Not isolated in feces unless contaminated with blood; no cases of AIDS or HIV infection associated with feces.
Cuts/puncture wounds	Use caution in handling sharp objects and searching areas hidden from view; needlestick studies show risk of infection is very low.
CPR/first aid	To eliminate the already minimal risk associated with CPR, use masks/airways; avoid blood-to-blood contact by keeping open wounds covered and wearing gloves when in contact with bleeding wounds.
Body removal	Observe crime scene rule: do not touch anything; those who must come into contact with blood or other body fluids should wear gloves.
Casual contact	No cases of AIDS or HIV infection attributed to casual contact.
Any contact with blood or body fluids	Wear gloves if contact with blood or body fluids is considered likely. If contact occurs, wash thoroughly with soap and water; clean up spills with 1:10 solution of household bleach.
Persistence of HIV in dried blood	Drying process inactivates virus in normal blood samples. Once dead, it is permanently dead; it cannot be brought back to life by rehydration. Laboratory studies showing persistence of AIDS virus for 3 days in dried blood sample used viral preparation 100,000 times more concentrated than found in normal blood samples. Not intended to show what happens in real world.

According to NIJ survey responses, inmate training in one-half of the state systems and almost two-thirds of responding city/county systems includes guidelines for "safer sex"—specifically, the use of condoms. Training in 20 percent of state systems and almost half of responding city/county systems also includes information on cleaning needles. Both of these topics are controversial because they refer to behaviors prohibited in (and, in the case of IV drug use, outside of) prison. Correctional systems should advocate abstinence from these practices as the safest approach, but realism suggests that not all inmates will be able or willing to abstain. Therefore, systems not already doing so might wish to consider presenting practical preventive measures for these inmates. (The issue of condom distribution in correctional facilities is discussed in Chapter Five.)

Content of AIDS Education and Training

As noted earlier, inmate and staff education programs should cover basic information on the causes and transmission of AIDS—debunking myths and unfounded rumors—and present practical, understandable guidance for preventing transmission and acquisition of the AIDS virus. We present some examples below of well-conceived inmate and staff educational materials. (Several lesson plans for inmate and staff training are included in Appendix D.)

Examples of Inmate Education/Training

Inmate training and educational materials almost always include discussion of sexual and needle-sharing practices likely to result in transmission of the AIDS virus. Materials should also emphasize the responsibilities of all inmates regarding all types of sexual activity and other potentially dangerous behavior. It is important for training to stress the practical precautions that everyone should take. The following excerpts effectively present key information:

> *–From a Texas inmate training curriculum:*[9]
>
> *How can the virus be transmitted?*
>
> We now know that the virus is found in most body fluids–blood, semen, vaginal secretions from women, saliva, tears, cerebrospinal fluid, amniotic fluid, urine, and breast milk. However, it appears that it depends on the *concentration*–on *how much* virus is present–before the virus can be transmitted. The evidence is that the virus is transmitted *only* through blood, semen, vaginal secretions, and possibly through breast milk.
>
> *How does the virus enter the body?*
>
> 1. *Sexual Contact.* Having sexual contact with an infected person, penis-vagina, penis-rectum, penis-mouth, mouth-vagina, mouth-rectum. Transmission can take place between a man and a woman or between two men . . . . Anal intercourse is the most dangerous behavior, because the penis can cause invisible tears in the rectum, allowing the virus to enter directly into the bloodstream. The same thing can happen in the vagina. The virus can be passed from penis to rectum or vagina or vice versa.
>
>   Although male homosexuals or bisexuals now have almost 70 percent of the cases of AIDS, it is expected that this percentage will decrease as heterosexual transmissions increase. Infection results from a sexual relationship with an infected person. The more sexual partners you have, *the greater is the risk of infection.*
>
> 2. *Blood contamination.* This happens when infected blood gets directly into the bloodstream. The most common way in the United States is the sharing of needles for IV drug abuse. Blood transfusions before May 15, 1985, were sometimes infected, but the chance of infection is *very small* now. Tattoo needles have transmitted the AIDS virus, and transmission might possibly occur by sharing razors or toothbrushes with an infected person. This is because of the risk of blood being on the tattoo needle, the razor, or the toothbrush.
>
>   The virus could enter the bloodstream if the blood of an infected person came in contact with a cut or with an open sore, or raw, chapped skin. In all instances, these transmissions would involve direct blood-to-blood contact. The virus may also be transmitted through mucous membranes lining the mouth and nose and through the eyes.
>
> 3. *Mother to child.* A woman who is infected with the AIDS virus may transmit the virus to her baby during pregnancy or child birth. It is also possible that it can be transmitted to a baby through breast-feeding.

> *–From a Florida inmate training curriculum:*[10]
>
> Responsibility for not contracting AIDS rests with you, the inmate, as an individual – homosexuality and IV drug use are personal choices.
>
> THE CHOICE IS YOURS – TO BE HEALTHY OR ILL.
>
> IT'S ALL UP TO YOU!

New York State's AIDS Institute conveys similarly sharp messages about individual responsibility regarding infection. In essence, the trainers say that people control their *own* risk of infection, that AIDS is behavior-bound and therefore 100 percent preventable–what you do, not who you are, determines whether or not you contract the virus.

Training programs should avoid stating or implying that members of certain groups are at risk and that all other people are basically "safe". This might create a false sense of security which could undermine the behavioral circumspection that everyone should practice.

However, inmate training should also stress that the AIDS virus is not transmitted by casual contact or normal health-care procedures and that the correctional system is taking reasonable and prudent steps to prevent spread of the disease. The following excerpts effectively convey these messages:

> *–From a Georgia inmate training curriculum:*[11]
>
> Even after all these years of studying thousands of AIDS cases, *no other methods of transmission have been found.*

There is no evidence that AIDS is transmitted through:

- being closely associated with an infected person on a daily basis;
- shaking hands, touching, or other nonsexual physical contact with an infected person;
- using utensils, trays, sheets, towels, or food that has been touched or used by an infected person;
- coming into contact with toilet seats, showers, recreational equipment, or any other facilities used by an infected person;
- being sneezed on, coughed on, or spit at by an infected person.

This Georgia curriculum also places the casual contact issue in the context of prison life:

> There is no evidence that *being in prison* increases the risk of developing AIDS. Nearly all of the inmates who have developed AIDS had a previous history of intravenous drug use, or shooting up, or homosexual activities. Inmates who have not engaged in homosexual activity, intravenous drug use, tattooing, or sexual activity with someone infected with the virus have no greater risk of developing AIDS than any other person.

—From "Questions and Answers on AIDS" in an Illinois inmate newspaper

(answers prepared by the state's correctional medical director):[12]

Question:

> Can AIDS be spread if someone were in the same cell with a person with AIDS?

Answer:

> Everything we know indicates that AIDS can only be spread through [sexual contact and needle-sharing]. No one who has lived in the same house as an individual with AIDS, including parents, brothers, sisters, friends, etc. has gotten AIDS from other household members. Even people who have kissed someone with AIDS and people who have shared the same glasses, eating utensils, and bathrooms as someone with AIDS have not developed AIDS. This proves to us that it is very difficult to spread AIDS.

Question:

> Can AIDS be spread from a needle used by a nurse to draw blood or give a shot?

Answer:

> Absolutely not. Only new, clean, sterile needles are used for blood drawing and giving shots.

Question:

> What is being done within the prison system to find out if anyone has AIDS?

Answer:

> Every individual who enters . . . [an institution within] the Department of Corrections has a complete history and physical as well as other tests. Any inmate who appears to be at greater risk of developing AIDS is put on a list and monitored very closely, including examination every 3 months. . . . When we identify someone who may, in fact, have AIDS we will enroll them in a special program so that they are followed up with other AIDS patients. . . .

It is important that inmate educational programs avoid both over-reaction to the AIDS problem and advocacy of unnecessary or inappropriate precautions. For example, some educational materials urge inmates to avoid sharing cigarettes and drinking cups as ways to avoid transmission of HIV. By recommending such measures, training programs are likely to perpetuate the erroneous impression that the AIDS virus can be transmitted by casual contact. This is just the sort of misinformation that training programs are intended to overcome. Rather, inmate training should emphasize practical precautionary steps:

—From a Texas inmate training curriculum[13]

Avoiding AIDS

A. The only completely safe behavior is to practice abstinence from sex and IV drugs. This means not having sexual relations with *anyone*, and not using any IV drugs. The next safest thing is to have sexual relations with only *one* partner—someone that you can be sure is faithful to *you*.

B. *Take precautions*. Use a condom if you are not sure of your partner (who did they sleep with before you, and did they ever use IV drugs?). *However*, this *will not* *eliminate* your risk completely. Condoms are *not* fail safe.

1. Use rubber, not skin.
2. Use spermicide (nonoxynol-9).
3. Use condom during *entire* sex act; the virus is also in pre-ejaculatory fluid.

C. Do not share *any kind* of needle with *anyone*. That means IV needle or tattoo needle or any other kind. Any needle that has been used by someone else may have that person's blood on it and the blood may contain the AIDS virus. If you put that needle into your arm, you will be injecting AIDS into yourself.

D. Do not share anything that could have someone else's blood on it. Remember that AIDS is passed through sexual contact and blood-to-blood contact.

Examples of Staff Education/Training

General training on the incidence and means of transmission of AIDS and on specific prevention measures (especially emphasizing "universal precautions") should be provided to all correctional line staff. Education must emphasize that transmission can occur outside, as well as inside, the correctional institution.

It is important that staff training programs begin by setting the proper tone and present a convincing rationale for the material to follow. The following example is effective in this regard:

—From a Washington state correctional staff training curriculum:[14]

> RATIONALE FOR COURSE
>
> As employees of the Department of Corrections, it is imperative that all of us be knowledgeable about "Acquired Immune Deficiency Syndrome" — commonly referred to as "AIDS". The more we know about it, the better able we are to deal with the problems associated with it and to allay the fears and anxieties of those offenders for whom we are responsible.
>
> As professionals, you have demanding jobs which involve a great deal of responsibility. At the institutional level, you are responsible for maintaining security and discipline, ensuring that a sanitary environment is maintained, keeping records, monitoring program activities, and so on. But, above all, you are "people workers" and, as such, you have a great deal of impact on the inmates for whom you are responsible. . . .
>
> In terms of AIDS and the impact it has on the way in which you deal with offenders, a professional attitude is critical. As corrections employees you must be concerned with the welfare and well-being of inmates. If inmates sense that you are concerned about their health problems and that you know what to do to help, they will be more inclined to respect you and to give you their cooperation. As a professional, your attitude should make clear that you *do* care. If you do not convey that attitude, regardless of your personal feelings, you do nothing other than invite problems.

Staff training should present a straightforward assessment of the risk of HIV infection associated with the correctional officer's work.

—From a California AIDS information sheet for correctional officers:[15]

> **Information On Aids For Correctional Officers**
>
> Some Correctional Officers have expressed concern about AIDS and other communicable diseases and how it affects the work place.
>
> THERE ARE NO REPORTED CASES OF PEACE OFFICERS CONTRACTING THE AIDS VIRUS DURING THE PERFORMANCE OF DUTIES.
>
> AIDS IS NOT TRANSMITTED BY:
>
> (1) Talking to an AIDS patient — INTERVIEWS
>
> (2) Touching an AIDS patient — HANDCUFFING, BODY SEARCHES
>
> (3) Riding in a vehicle with an AIDS patient — TRANSPORT
>
> (4) Touching objects handled by an AIDS patient — CELL SEARCHES, EVIDENCE GATHERING
>
> (5) Working with an AIDS patient

The following are further examples of accurate and reasonable presentations of risks:

—From a New York state brochure for correctional staff:[16]

Question:

> I've been brown bagging it in case the cafeteria food or dishes are handled by AIDS patients. Am I being too cautious?

Answer:

> Yes. Working in the same area, breathing the same air, touching the same things (such as dishes and eating utensils) will *not* give you AIDS.

Question:

> I've been assigned to work in a unit where AIDS patients are housed. Am I in danger of getting AIDS?

Answer:

> You would be at risk *only* if your job placed you in situations in which body fluids from an AIDS patient could directly enter your body or bloodstream. There is no reason to believe, for example, that a person would get AIDS as a result of washing floors on an AIDS unit.

Just as with inmate training, it is important to emphasize that HIV is not transmitted by any form of casual contact and to advocate only measures designed to address known means of transmission or to prevent activities involving a significant risk of transmission. In general, this means applying universal infection control procedures. Precautions designed to prevent transmission of Hepatitis-B are more than sufficient to prevent transmission of AIDS, since AIDS is more difficult to transmit. Measures more restrictive than those applied to Hepatitis-B are unnecessary and inappropriate for addressing the AIDS risk. (Specific prevention measures are discussed in detail in Chapter Five of this report.) The following excerpts effectively capture some of the key precautions for correctional officers:

—From a training curriculum for jail officers in Phoenix, Arizona:[17]

There are several very simple tasks which you can do that have been shown over and over again to prevent the spread of infectious diseases, AIDS included.

First: If you anticipate coming into contact with blood such as during an assault or an injury, put on disposable rubber gloves and avoid contact with your skin, especially if you have any open cuts or wounds.

Second: After contact with suspected contaminated materials, *thoroughly wash* your hands and all areas which were exposed to contamination. A simple solution of household bleach diluted 1:10 is sufficient to kill the AIDS virus. Containers of bleach are available at several stations throughout each jail. Contaminated surfaces should be thoroughly cleaned with this dilute bleach solution.

Third: Use extra care in handling objects which are contaminated with blood. Do not resheath needles but dispose of them in the proper impervious containers. Make sure you do not injure yourself with sharp objects such as razors or contraband weapons. When disposing of possibly contaminated material, ensure that it is properly wrapped and labeled so that others are not inadvertently injured.

These steps are so obvious that they are often neglected, yet they are your best defense against the spread of blood-borne diseases. Should you ever encounter a situation where there may be contamination it pays to take your time and follow the above advice.

—From a Texas staff training curriculum:[18]

Following are guidelines and precautionary practices security officers should observe during their tour of duty:

A. *Cell and Body Searches*

1. Make sure any open wounds and sores are covered with clean bandages to prevent possible exchange of blood.
2. Wear protective gloves if there is a chance of contact with blood or body fluids (urine, saliva, feces, vomit) on an inmate, clothing, or linen.
3. Avoid needle sticks or punctures with any sharp objects (e.g., knives or razors that may be contaminated with blood) on the inmate's body.
4. Never blindly place hands in areas where there may be sharp objects that could cut or puncture the skin, and be

particularly alert for such objects during cell searches.

5. Wash hands with soap and warm water following every search.

> *—From a Washington state correctional staff handout on AIDS*:[19]
>
> WHAT ARE THE PRECAUTIONS TO BE TAKEN WHEN GIVING . . . CPR?
>
> Cardiopulmonary resuscitation must be given to people in need of this life-saving procedure. While there is always some risk of being exposed to a communicable disease when giving CPR, the risk is considered to be small.
>
> To minimize the risk of contamination, the Department will ensure that "pocket masks" are strategically located and readily available to all staff when emergency resuscitation must be initiated. However, if a mask is not immediately available, mouth-to-mouth must be initiated when necessary to save a life.

Finally, staff training should emphasize the importance of maintaining confidentiality regarding AIDS cases. The following excerpt effectively accomplishes this:

> *—From a Washington state correctional staff handout on AIDS*:[20]
>
> WHEN DEALING WITH AIDS, ARE THERE SPECIAL CONSIDERATIONS RELATED TO CONFIDENTIALITY?
>
> The answer to this question is "yes and no". No, in the sense that DOC requires confidentiality in all medical matters except on a "need to know" basis. Yes, in the sense that violating confidentiality concerning AIDS can have far greater consequences and cause a threat to the security and the welfare of offenders and staff. Violating an offender's right to confidentiality is in violation of law and makes the person who violates that confidentiality personally liable for the consequences.

Documenting Training Attendance and Receipt of Educational Materials

Where participation in inmate training programs is voluntary, it is wise for administrators to maintain a written record of those who did and did not choose to attend and those who received educational materials. In Maine, inmates may attend training or choose not to attend, but in either case they must acknowledge their choice in writing. Minnesota also has a sign-up system for AIDS training. New York City placed copies of its AIDS policy in each staff member's paycheck envelope and required each to sign for its receipt along with their check. The California Department of Corrections also distributed AIDS information to staff with paychecks, and requires all inmates who are released to sign for AIDS information materials.

Such records may be useful in the event of a lawsuit. They may help the correctional system to build an "assumption of risk" defense to a suit alleging that its officials were negligent in the infection of an inmate or staff member. In other words, the system should be able to demonstrate that the individual was provided education on the types of behaviors associated with transmission of the virus and the precautionary measures recommended to prevent acquisition of the virus. If the individual chose not to receive (or chose to ignore) this training and education, he or she assumed the risk of engaging in those behaviors and the system should not be held responsible for the result. Of course, this defense would only be applicable if transmission of the infection occurred through a consensual act or through personal carelessness or negligence.

Evaluating Education and Training

Correctional systems should periodically evaluate their AIDS training so that it can be updated and improved. AIDS training and education programs can be evaluated in various ways. Some systems use pre- and post-tests of knowledge and find these a satisfactory method of evaluation. To judge knowledge retention, institutions might consider administering follow-up post-tests some time after training is delivered. Inmates and staff should also be asked to evaluate training sessions and make suggestions for augmentation and improvement.

The California Department of Corrections assesses the distribution and impact of AIDS educational materials in its institutions. In the assessment, staff and inmates are asked whether they have seen particular brochures and other materials and whether these materials have been helpful to them in understanding AIDS. Staff are also asked to list typical inmate questions on AIDS and whether the materials provided by the department enable them to answer these questions. Inmates are also asked to assess the answers they are receiving to AIDS-related questions. This assessment appears to be a useful method of collecting feedback on AIDS informational materials and improving the system's AIDS information dissemination program.

Conclusion

Education and training represent the keystone of the correctional systems' response to AIDS. Virtually all responding correctional systems are now providing some AIDS education to both inmates and staff. Live training has become much more prevalent in the two years since the first NIJ study. Education and training are particularly necessary because of the persistence of misinformation, as well as rational concerns, regarding AIDS. NIJ survey results show that staff and inmate concern about AIDS have not declined significantly in the last year.

This chapter has discussed the following key elements of AIDS education and training:

- AIDS training should be timely—that is, if possible, it should be presented before widespread concern takes hold.
- AIDS training should be regularly presented and regularly updated to respond to changing information and the often misleading media coverage of AIDS. Misinformed fear will reassert itself without frequent doses of accurate information.
- AIDS training should be mandatory for inmates and staff. This will be expensive and logistically challenging, but the cost and trouble are justified because the topic is of such great importance.
- Correctional systems should involve inmates and staff in the development of AIDS educational programs. This can be done by soliciting particular questions and concerns and using them as the basis of the training.
- AIDS training should be live, so that inmates have a chance to ask questions and receive answers from knowledgeable speakers.
- Live training should be supplemented with videotapes and/or written informational materials.
- All educational programs and materials should use simple, non-technical language understandable to the audience.
- Credibility is absolutely critical to the success of AIDS training. Systems can build credibility by using knowledgeable and approachable trainers, ensuring that all training is factual and consistent, and by using peer trainers or training teams.
- AIDS education should avoid extremes of alarmism and complacency. It should neither advocate unnecessary and inappropriate measures nor encourage a false sense of security in any group. Rather, training should emphasize that *everyone* must avoid certain well-defined behaviors and exposures.
- AIDS training should be keyed to the specific concerns of a correctional audience. Strictly generic materials are insufficient.
- AIDS training content should focus on specific risks and specific practical precautionary measures for inmates and staff. Inmate training should stress abstinence from drug use and sexual activity. However, as a realistic response, many correctional systems also include "safer sex" guidelines and information on cleaning needles.
- All AIDS training and materials distribution should be documented in case of future lawsuits. This may enable systems to counter claims that insufficient training on risks and precautions was provided.
- AIDS training and education should be periodically evaluated so it can be updated and improved.

70

Notes

1. "Report of the Massachusetts Sheriffs' Association Task Force on AIDS in County Correctional Facilities." June 25, 1987.
2. American Friends Service Committee (Cambridge, Mass.), *Outlook on Justice* (November-December 1987).
3. See, for example, W. Winkelstein, et al., "The San Francisco Men's Health Study: Reduction in HIV Transmission Among Homosexual/Bisexual Men, 1982-1986," *American Journal of Public Health*, 1987; 77:685-689; D.C. Des Jarlais, and S.R. Friedman, "Editorial Review: HIV Infection Among Intravenous Drug Users: Epidemiology and Risk Reduction," *AIDS*, 1987; 1:67-76.
4. "Report of the Massachusetts Sheriffs' Association Task Force on AIDS."
5. D. Mackintosh, et al. "Final Report: Training and Education Workshops for Correctional Staff and Community Health Care Workers," (submitted to the National Institute on Drug Abuse, July 8, 1987).
6. Copies of the videotape are available without charge by sending a blank VHS cassette with a self-addressed mailer to Charles Hernandez, Superintendent, Taconic Correctional Facility, 250 Harris Road, Before Hills, New York 10507, Telephone (914) 241-3010.
7. Ronald Shansky, M.D., Draft for Inmates News paper (October 1985).
8. New York State Health Department, "AIDS Information for New York State Correctional Services Department Employees," March 1985.
9. Texas Department of Corrections, Health Services Division, AIDS Education for Inmates, October 20, 1987.
10. Florida Department of Corrections, "AIDS: Could You Be At Risk? You Make the Choice." (n.d.).
11. Georgia Department of Corrections, AIDS Lesson Plan for Inmates, (n.d.).
12. Ronald Shansky, M.D., Draft for Inmates News paper (October 1985).
13. Texas Department of Corrections, AIDS Education for Inmates, October 20, 1987.
14. Washington Department of Corrections, "AIDS Lesson Plan," (November 14, 1985).
15. California Department of Corrections, Office of Health Care Services Information on AIDS for Correctional Officers, April 1987.
16. New York State Department of Correctional Services, "AIDS Information for New York State Correctional Services Department Employees" (March 1985).
17. Correctional Health Services, Phoenix, Arizona, "AIDS and Your Job," (November 18, 1985).
18. Texas Department of Corrections, In-Service Training Division, AIDS Curriculum, September 1987.
19. Washington Department of Corrections, "AIDS Lesson Plan," (November 14, 1985).
20. Washington Department of Corrections, "AIDS Lesson Plan," (November 14, 1985).

Chapter 4: HIV Antibody Screening and Testing

This chapter addresses the controversial issues of whether and under what circumstances HIV antibody tests should be used in the correctional setting. There appears to be significant confusion about the nature and meaning of HIV antibody testing. Although terms such as "AIDS testing" are often used, and individuals are commonly said to have "tested positive for AIDS," the fact is that *there is no blood test for AIDS*. As emphasized in Chapter One, the available tests do not determine whether or not an individual has AIDS; rather, AIDS can only be diagnosed through identification of "indicator diseases." Indeed, the test does not detect the presence of HIV itself—only the presence of antibodies to the virus. A confirmed positive result (using the double ELISA and Western Blot—see Chapter One) only means that the individual was infected sometime in the past. Medical researchers generally agree that more than one-half of infected individuals (currently estimated to number 1-1.5 million in the United States) will go on to develop ARC or AIDS. However, because the incubation period of AIDS is both prolonged and uncertain, it is impossible to predict either how many or which particular seropositive persons *will* develop symptoms. For counseling and public health purposes, CDC recommends that all seropositive persons be considered infected and potential carriers of the virus.

The major possible applications of HIV antibody testing in correctional inmate populations are mass screening, risk-group screening, testing in response to potential transmission incidents, voluntary testing, voluntary testing on request, testing in support of blind epidemiological studies, and testing in the presence of clinical indications or symptoms. Testing of staff may also be undertaken in limited instances. All of these applications are discussed below. A particular focus is the perceived advantages and disadvantages of mass screening programs. The chapter also summarizes the testing procedures actually adopted by state and local corrections authorities.

Mass Screening for Antibodies to HIV: The Debate

Mass screening means mandatory testing of individuals for antibodies to HIV, in the absence of any clinical indications of disease, in order to identify specific individuals who may be infectious. Mass screening usually involves testing all inmates, all new inmates and/or all inmates prior to release. A more limited form of screening involves testing all inmates with discernible histories of high-risk behavior (e.g., homosexual/bisexual males, intravenous drug abusers, prostitutes).

There continues to be significant controversy about the wisdom and utility of mass screening in the correctional environment. This chapter will review the major arguments in the debate. However, it is important to establish at the outset the boundaries of that debate. The only legitimate purposes of which mass screening in a correctional setting are:

1) to reduce transmission of HIV in correctional institutions;

2) to improve medical monitoring of and medical care for infected inmates; and/or

3) (If screening is done pre-release) To inform counseling and supervision of releasees regarding their behaviors in the outside world.

Any decision to institute mass screening must be based on a full and highly specific understanding of how the program will achieve these objectives, and on a determination that its expected success in achieving them outweighs the possible harmful effects of the program on the lives of inmates and the security of the institution. Before mass screening is implemented, the correctional authority should have decided exactly how it will use the test results to achieve these objectives and satisfied itself that the funds to be used for the program could not be better expended on AIDS education or other preventive strategies.

Unfortunately, intense political pressure now surrounds the issue of mass screening and this has too frequently outweighed the need for a full and rational assessment of the specific objectives and possibly deleterious effects of testing programs. Indeed, responses to the NIJ survey indicate that many correctional systems are under great pressure from governors, legislatures, the media, and the public to begin mass screening. Based on NIJ survey responses, sixty percent of all state systems and almost 60 percent of states that have adopted mass screening report receiving such pressure.

Twelve state systems and the Federal Bureau of Prisons have mass screening programs, up from just three

Figure 4.1

CORRECTIONAL SYSTEMS WITH MASS SCREENING OR RISK GROUP SCREENING PROGRAMS, OCTOBER 1987

	State/Federal	City/County
Mass Screening[a]	Federal Bureau of Prisons, Alabama, Colorado, Idaho, Iowa, Missouri, Nebraska, Nevada, New Hampshire, Oklahoma, South Dakota, West Virginia, Utah (planned)	None
Risk Group Screening[b]	Alabama, Alaska, Arkansas, Colorado, Connecticut, Idaho, Indiana, Kansas, Michigan, Mississippi, Nebraska, New Mexico, North Dakota, Texas, Vermont, Wisconsin	Maricopa (AZ) Alameda (CA) San Francisco (CA)[c] Broward (FL) Dade (FL) Fulton (GA) Hennepin (MN) Westchester (NY) King (WA)

---

[a] Defined as mandatory testing of all new inmates, all releasees, and/or all current inmates regardless of the presence of clinical indications.

[b] Defined as testing of members of at least one AIDS "risk group"—e.g., homosexual/bisexual males, intravenous drug users, prostitutes, pregnant females (because of the possibility of perinatal transmission).

[c] Anonymous testing only.

states in 1986. The Federal system screened all new inmates for several months, but recently decided on testing only a 10 percent random sample of incoming inmates and *all* inmates on release. In addition, sixteen state or federal systems and nine city and county systems have instituted "risk-group" screening programs, up from eleven and six last year (Figure 4.1). In Canada, no systems have instituted mass screening but three systems have undertaken risk-group screening. Because of rapid population turnover in jails, screening to identify carriers of HIV is probably impractical in these institutions. This is particularly true of jails housing only (or primarily) pre-trial detainees. Indeed, no responding city or county correctional systems have instituted mass screening.

To be sure, not all jurisdictions that have undertaken mass screening have done so in response to political pressure. Many of these decisions were based on a firm conviction that mass screening is the most effective way for correctional systems to discharge their responsibility to protect their inmates and staff from infectious diseases and to provide high-quality medical monitoring and medical care. Seven systems which have instituted mass screening cite identification of carriers as a rationale for the decision, six cite targeting of education programs and seven cite improved diagnosis. Notably, the largest proportion (11, or 85 percent) of mass screening jurisdictions listed a desire to estimate the extent of the AIDS problem as a reason for their policy. As will be discussed below, however, such estimates can be developed through blind epidemiological studies which avoid many of the difficulties associated with identity-linked mass screening.

Some correctional systems have had a mass screening policy imposed upon them by their executive or legislature. These mandates have often reflected the mistaken view that mandatory HIV antibody testing somehow represents a "magic bullet" for the problem of AIDS or results from a political impulse to show the public that "we're doing something about AIDS."[1]

As reflected in responses to the third annual NIJ survey, however, more than 75 percent of state correctional systems still believe that the disadvantages of mass screening outweigh the potential benefits. Those who have decided against mass screening stress concerns about the accuracy of the tests, inability to maintain confidentiality of results and resulting ostracism of and violence against inmates believed to be infected, the costs and inherent logistical problems, the fact that feasible alternatives exist, and, most importantly, the belief that mass screening is not the most effective strategy for reducing transmission of

HIV within correctional facilities and improving the quality of medical care for infected inmates. Screening on discharge does not address these two objectives but has other benefits and poses fewer institutional management issues. Of course, screening on release may lead to discrimination if results are divulged. The central issues in the complex debate over mass screening in correctional facilities are reviewed below.

Are HIV Antibody Tests Reliable and Accurate?

If the benefits of a mass screening program are to outweigh its disadvantages, then the program must offer highly accurate and reliable results. If, for example, inmates are to be segregated or otherwise managed differently on the basis of test results, then the correctional system must be confident that it has identified, with a high degree of accuracy and completeness, the group to receive such differential management. Indeed, there may be legal liability associated with mislabeling an inmate as HIV-seropositive.

Proponents of mass screening argue that the HIV antibody tests are highly reliable. Others identify two areas of serious concern about their reliability: 1) the problem of lag-time between infection and the appearance of detectable antibodies, which means that certain truly infected individuals will not be identified; and 2) technical problems with the tests and testing procedures which may produce incorrect results—particularly false positives.

Lag-Time Between Infection and Appearance of Antibodies

CDC estimates that, on average, six-twelve weeks elapse between an individual's infection with HIV and the appearance in the blood of detectable antibodies to the virus.[2] However, there have been isolated reports of lag-times up to six months, and recent data suggest that even longer delays in antibody appearance may not be unusual.[3]

These facts are extremely important, because infected individuals are capable of transmitting the virus from the instant they are infected. Infectiousness, in other words, does not await the appearance of detectable antibodies. Negative antibody test results based on blood drawn during this lag-time are, in effect, false negatives. Such instances have produced the very small number of HIV infections associated with transfusions administered since universal screening of blood supplies began in 1985. The blood transfused in these cases was donated by infected persons before the antibodies had appeared.

The lag-time problem should also be of concern to correctional administrators contemplating any type of mass screening program. It means that it is impossible to guarantee detection of all infected members of a population through one-time screening. Leaving aside the other reliability problems (discussed below), repeated followup testing of populations would be necessary to maximize the probability of detecting all infected individuals. This may have serious cost and logistical implications.

Technical Problems with the Tests

Interpretation of results is a key factor in the ultimate reliability of the ELISA test. The results of the test are measured on a continuous numerical scale representing a color density reaction to the level of antibodies in the blood. Therefore, a decision must be made as to the "cutpoint" on this scale that distinguishes positive and negative results. Manufacturers recommend setting a specific cutpoint for each test kit based on the degree of reaction to the known positive and negative control samples supplied.[4]

Because the ELISA was initially developed to screen blood, the recommended cutpoints are deliberately set quite low to minimize false negative results. When screening blood, it is better to discard possibly uninfected units than to use possibly infected units. Of course, the low cutpoint designed for blood screening produces a relatively large number of false positives when the test is used to screen people.

HIV antibody tests are subject to error, even when recommended confirmatory procedures are used. The major problem appears to be with false positive results, although false negatives may also occur, particularly in the high-risk populations of interest to correctional agencies. False positives are of particular concern to persons being tested, who may suffer mental anguish and be subjected to severe discrimination. On the other hand, false negatives are of particular concern to persons who may subsequently be infected by individuals they believe to be free of HIV. Both problems should be of serious concern to correctional agencies and must be carefully considered before any testing program — and particularly, any mandatory testing program — is instituted.

The *precision* of a biomedical test is expressed in terms of the consistency of its results — that is, it is highly precise if it always yields the same results when repeated under similar circumstances. However, HIV

Figure 4.2

HYPOTHETICAL HIV ANTIBODY SCREENING IN A POPULATION OF 500 WITH A 20% TRUE PREVALENCE OF INFECTION

		True Infection Status		Antibody Test Results		False Results as % of True Group
		n	%	Negative Result	Positive Result	
True Groups	Infected	100	20%	1	99	1%[a]
	Uninfected	400	80%	396	4	1%[b]
	Total	500	100%	397	103	
	False Results as % of all Test Results in Category			0.3%[c]	3.9[d]	

---

[a] This reflects the test sensitivity of 99%.

[b] This reflects the test specificity of 99%.

[c] This is the percentage of all negative results which would be false.

[d] This is the percentage of all positive results which would be false.

antibody test results have been shown to be affected by relatively minor variations in temperature, humidity, and other factors.[5]

Procedural variations and quality control deficiencies can also adversely affect the performance of HIV antibody tests. The Western Blot is particularly susceptible to human error and variability of results because most laboratories use unlicensed test kits.[6] As a result, unlike the ELISA test, the Western Blot test is usually not based on a standardized product. However, the ELISA is also subject to variation because of the possibility that different testing facilities will use different criteria for setting the positive-negative cutpoint which is critical to interpreting the test results.

The *accuracy* of biomedical tests is generally measured in terms of sensitivity and specificity. CDC estimates that the sensitivity and specificity of currently-licensed ELISA tests are both 99 percent or higher (assuming that a double ELISA test is performed), and these estimates do not appear to be in question. Ninety-nine percent sensitivity means that, on average, the test will correctly identify ninety-nine out of every hundred infected individuals. Ninety-nine percent specificity means that, on average, the test will correctly identify ninety-nine out of every hundred uninfected individuals.

In other words, 1 percent of actually infected persons will be false negatives on the test, and 1 percent of actually uninfected persons will be false positives on the test. This does not mean, however, that 1 percent of all positive or negative tests will be false. The percentage of positive (or negative) results which are false depends on the true prevalence of infection in the tested population and on the sensitivity and specificity of the test.

Consider the two examples depicted in Figures 4.2 and 4.3. In Figure 4.2, the true prevalence of infection in a population of 500 is 20 percent. The sensitivity and specificity of the test are both assumed to be 99 percent. There are 400 uninfected persons of whom about 1 percent, or four people, will have a false positive test result. About 1 percent, or one, of the 100 infected persons will have a false negative test result. Thus, a total of 103 people will test positive, of whom four will be false positives—3.9 percent of all positive results will be false.

Figure 4.3 shows that when the true prevalence of infection is lower, the rate of false positives will increase, simply because there will be a larger number of truly uninfected individuals, about 1 percent of whom would test falsely positive. In Figure 4.3, the true prevalence of infection is 1 percent in the hypothetical

Figure 4.3

HYPOTHETICAL HIV ANTIBODY SCREENING IN A POPULATION OF 500 WITH A 1% TRUE PREVALENCE OF INFECTION

		True Infection Status		Antibody Test Results		False Results as % of True Group
		n	%	Negative Result	Positive Result	
True Groups	Infected	5	1%	0.05	4.95	1%[a]
	Uninfected	495	99%	490	5	1%[b]
	Total	500	100%	490.05	9.95	
	False Results as % of all Test Results in Category			0.01%[c]	49.8%[d]	

---

[a] This reflects the test sensitivity of 99%.

[b] This reflects the test specificity of 99%.

[c] This is the percentage of all negative results which would be false.

[d] This is the percentage of all positive results which would be false.

population of 500, and the percentage of positive results which are false rises to almost 50 percent. The number of false positives would continue to rise with increases in the size of the tested population.

Thus far, the discussion assumes that only a double ELISA test has been performed. Reducing false positive rates depends heavily on the ability of the Western Blot confirmatory test to eliminate falsely positive results from ELISA tests and thus increase the specificity of the entire test sequence. *Properly performed*, the Western Blot is more highly specific than the ELISA. Assuming it improves specificity by about one-half of 1 percent, the percentage of positive results which are false in the hypothetical high-prevalence population (Figure 4.2) above would be cut in half (to 2 percent), while in the lower-prevalence population (Figure 4.3), it would be reduced by about one-third to 34 percent — still a very significant proportion.

Unfortunately, as noted, the Western Blot, as performed in most laboratories, is not a standardized test like the ELISA. Therefore, its application is more susceptible to variation and its overall performance is less amenable to systematic evaluation.[7] Nevertheless, these hypothetical results underscore the importance of the Western Blot test in reducing the number of false positives. In any testing program, great care should be taken to maximize quality control in all phases, but particularly in the Western Blot confirmatory phase.

Because of the apparent susceptibility of these tests (particularly the Western Blot) to quality control problems, and because of the dramatic effect of losing even a fraction of 1-percent in specificity to such problems, several researchers contend that the numbers of false positives will be unacceptably high in populations where the actual incidence of infection is very low (such as persons applying for marriage licenses or positions as police officers). These researchers have calculated that the percentage of positive results which will be false after the entire test sequence (including the Western Blot) in very low-risk populations could be in the range of 28 percent-90 percent.[8] Indeed, Figure 4.3 has demonstrated that almost 50 percent of positives would be false in a population with a one-percent true prevalence of infection.

Figure 4.4 illustrates the problem in the correctional setting. Based on NIJ survey results presented in Chapter Two, the prevalence of HIV infection in most prison populations in the United States is probably between 0.5 percent and 5 percent, with a few jurisdictions sharply higher. Figures recently released by the Federal Bureau of Prisons (FBOP) indicate that less than 3 percent of federal prisoners are infected with

Figure 4.4

HYPOTHETICAL APPLICATION OF MASS SCREENING FOR ANTIBODIES TO HIV IN A POPULATION OF 25,000 INMATES

True Prevalence of Infection	False Positives by Test Sequence Specificity[a]					
	99.5%		99.9%		99.99%	
	n	%[b]	n	%[b]	n	%[b]
0.5%	124	50.0%	25	16.7%	2	2.0%
1	124	33.2	25	9.0	2	1.0
3	121	14.0	24	3.1	2	0.3
5	119	8.7	24	1.9	2	0.2
10	113	4.3	23	0.9	2	0.1
20	100	2.0	20	0.4	2	0.04
30	88	1.2	18	0.2	2	0.03

---

[a] Test sequence sensitivity is assumed throughout to be 99.5%. With 99.5%, 99.9%, and 99.99% specificity, .5%, .1% and .01%, respectively, of truly uninfected persons will be false positives.

[b] False positive results as a percentage of all positive results. In calculating this percentage, positive results include all truly infected persons, minus false negatives, plus false positives.

HIV.[9] Figure 4.4 represents a hypothetical application of mass screening for HIV antibodies to a population of 25,000 inmates, when the true prevalence of infection ranges from 0.5 percent to 30 percent and the specificity of the entire testing sequence ranges from 99.5 percent to 99.99 percent—a range encompassing the values assumed by most researchers. The sensitivity of the test sequence is held constant at 99.5 percent.

The percentage of positive results which would be false under this hypothetical application of mass screening shows dramatic variations. At one extreme—99.5 percent specificity and 0.5 percent true prevalence—fully one-half of confirmed positive results will be false. More than 120 uninfected inmates would be mislabeled as HIV-infected, with all of the potential problems associated with such a designation. Even at 99.9 percent specificity and 1 percent true prevalence, almost 10 percent of positive results would be false—a not insignificant proportion. At the other extreme, if we assume 99.99 percent test sequence specification, the percentage of positive results which would be false is extremely low regardless of the true prevalence of infection. A hypothetical number and percentage of positive results which would be false may be easily calculated for any scenario by substituting the population size, estimated true prevalence of infection, and estimated test sequence sensitivity and specificity.

Again, these results demonstrate the importance of maximizing the specificity of the test sequence. The potentially high percentages of false positive results in low-prevalence populations also underscore the importance of determining in advance how tests results are to be used. In any setting, the consequences of being identified as seropositive may be severe—but the effects are probably more serious in a correctional environment than elsewhere. Seropositive inmates may be segregated, ostracized, and/or physically abused. Therefore, if a high percentage of positive results may be false, the negative consequences of testing may far outweigh the presumed benefits.

Just as low-risk populations may present a serious false-positive problem, in high-risk populations, the problem of false negatives may reach fairly serious proportions.[10] For example, in the New York state prison population of about 35,000 inmates where the true prevalence of infection is estimated by officials to be about 30 percent, over fifty infected persons would not be identified through an HIV antibody screening program, assuming test sensitivity of 99.5 percent. Although the percentage of negative results which would be false is very low (less than one-half of 1 percent), the absolute number of false negatives would pose real problems if efforts to reduce transmission were based on segregating seropositive inmates.

This should be of real concern to any policy-maker considering HIV antibody screening as the basis of controlling the spread of infection in a high-risk population.

Further complicating the picture is the possibility raised by some researchers that intravenous drug users and certain other groups—including women who have borne more than one child, persons who have received blood transfusions, persons with alcoholic hepatitis, and homosexual men who have participated in receptive anal intercourse—may be prone to false positive results. This is because, for various reasons, they all may have antibodies in their systems mistakenly recognized by the ELISA test as antibodies to HIV.[11] In general, these diverse potential problems suggest the need for real caution in decisions to institute any large-scale testing program.

Can Mass Screening Prevent Transmission of HIV?

As emphasized above, correctional systems should be convinced that mass screening will actually reduce transmission of HIV and should have determined how the test results will be used to achieve this objective, before they decide to institute such a program.

Proponents of mass screening argue that HIV antibody screening facilitates policies that will reduce transmission. They argue that seropositive individuals should be identified so they may receive special housing, supervision, counseling, education and other programming. Such steps, proponents believe, will most effectively prevent transmission of the virus to other inmates and to staff. They feel this will be valuable for staff to know which inmates are infected so they can take special precautions when dealing with them. It will also be valuable to use HIV antibody status—in combination with other information regarding the inmate's potential for assaultive, sexually predatory, or promiscuous behavior—to make key classification decisions. Limited space for segregation and other special housing, proponents contend, require narrowing the focus to inmates who are both HIV seropositive *and* pose serious potential behavior problems.

Critics, on the other hand, respond that sophisticated classification procedures possibly using resources diverted from mass screening can effectively identify predators, victims, and others likely to be involved in high-risk behaviors, and effectively minimize opportunities for such activities to occur. In particular, critics suggest that funds which might be required for mass screening could better be used to prevent rapes and other victimization that may lead to transmission of HIV in correctional facilities.[12] They believe it more appropriate, in short, to focus on identifying predators and preventing victimization than on trying to identify all seropositives, many of whom may pose no behavioral problems.

Critics also suggest that mass screening may not be an effective way to promote behavior change and reduce transmission of HIV. Serious questions have been raised as to whether knowledge of antibody status will lead to salutary behavior change. Indeed, some have argued that persons with sociopathic (psychopathic) personalities, which are common among correctional inmates, may instead tend to exhibit increasingly reckless and irresponsible behavior if informed that they are infected with HIV. In other words, they may set out deliberately to infect others. As a result, it may be very difficult for correctional systems to deal with HIV seropositives once they have been identified. Issues arise concerning special housing and programming that may not be medically necessary but may be considered appropriate to maintain institutional security and order. This is a particularly serious concern for systems that are likely to have large numbers of seropositive inmates and may be unable to meet demands for segregated housing.

From the standpoint of staff safety, the questions may be asked: What specific special precautions could staff take to protect themselves from infected inmates if they knew these inmates' identities? In other words, what could they do in specific situations, such as assaults or fights, if they knew the inmates' antibody status that they would not or could not do in the absence of such information? On the contrary, health-care workers, correctional workers, and others should be urged to avoid unprotected contact with the blood or body fluids of *everyone*. It is not necessary to know individuals' antibody status in order to implement such precautions. Indeed, such knowledge undermines the implementation of universal precautions by inevitably creating a double standard. As the discussion of test reliability indicates, mass screening will not be able to identify all infected individuals, so a far preferable policy may be to apply the same standard precautions to all inmates.

Specific policy options for managing HIV seropositives (such as administrative segregation, single-celling, and maintaining them in the general population) will be discussed in Chapter Five. However, the critical point here is that decisions about the programmatic implications of testing must be reached before any such program is initiated. In some systems, for instance, the expected cost of separate housing and programming for large numbers of seropositives seems to have heavily influenced decisions against mass screening. In other systems, however, particularly those where rates of seropositivity are expected to be low, correctional authorities may believe that the benefits of identifying seropositives will outweigh the negative consequences of a screening program.

Not surprisingly, therefore, survey results show that HIV antibody screening has been most often adopted in states with very few inmates AIDS cases: 92 percent of states doing mass screening, and 64 percent of states doing risk group screening, have had fewer than four AIDS cases among inmates.

Will Mass Screening Improve Medical Monitoring and Care?

Proponents of mass screening argue that identifying seropositives will facilitate timely medical monitoring diagnosis and intervention. They suggest that staff and resource limitations preclude intensive medical monitoring of all inmates, particularly those who are displaying no overt symptoms of illness. Screening allows medical staff to focus their monitoring on those inmates most likely to need attention so that diagnosis and treatment can be carried out on a more timely basis.

Critics argue that it is unfair to subject inmates to the inevitable stigma associated with a label of HIV-infected if no effective cure or therapy can be given to them in return. Moreover, they contend, there are reasonable alternatives to mass screening for the proactive identification of inmates most at risk for HIV infection.

In general, physicians who oppose mass screening argue that medical surveillance and diagnosis must be seen as a process that involves asking the right questions in history-taking, performing the correct physical examinations, and being carefully attuned to the signs and symptoms of ARC and AIDS. HIV antibody testing cannot substitute for this total and ongoing process. If properly done, history-taking and physical examinations may be viable alternatives to HIV screening and may avoid the potential negative effects of screening. History-taking and physical examinations may help to identify those inmates at highest risk for being infected or developing ARC or AIDS, and may also yield opportunities to provide important educational information regarding the transmission of HIV infection.

Careful and complete history-taking includes standardized questions on ARC symptoms and on lifestyle and health habits. It should be recognized, of course, that information provided by inmates regarding their lifestyles – particularly intravenous drug use and sexual activity – may not be fully reliable. Therefore, particular attention must be paid to physical indicators and other clues to the presence of risk factors. An expanded physical examination for HIV-related factors includes more careful oral/pharyngeal examination, lymph node search, and anal examination. (Examples of screening and history-taking protocols from Maryland and several other states are included in Appendix F.)

Follow-up on the history-taking and physical examination includes careful medical surveillance of signs and symptoms and tracking of individuals at risk for HIV infection. Several jurisdictions have instituted comprehensive programs for identifying and tracking inmates with histories of high-risk behavior, in clear preference to large-scale antibody testing. For example, Illinois medically monitors all inmates with histories of intravenous drug abuse and current lymphadenopathy, as well as all homosexual and bisexual inmates. These inmates all receive a physical examination (including white blood count) every three months. Illinois has a "tickler file" system to ensure that these examinations are carried out as scheduled. Texas, Indiana, and San Francisco also identify and monitor inmates at apparent high risk for HIV infection.

Is It Possible to Maintain the Confidentiality of Antibody Test Results in Correctional Facilities and How Does Disclosure Affect Seropositive Inmates?

Proponents of mass screening argue that confidentiality of test results can be effectively maintained in a correctional institution. Care can be taken to ensure that results are not entered in inmates' medical records and that any lists of seropositive inmates are always kept locked and secured from unauthorized access. (The complex and controversial question of who should be authorized access to results of any HIV antibody testing – mass screening or selective testing – is discussed in Chapter Six.)

Critics suggest that confidentiality of such sensitive information is impossible to maintain in a prison or jail and that, when results or rumored results inevitably become known, serious difficulties are almost sure to befall seropositive inmates. One prison physician noted that the "inmates' communication system is better than the staff's." Of course, confidentiality is less likely to be maintained – and perhaps less important, at least insofar as inmate saftey is concerned – if seropositives are segregated or otherwise housed separately. Moreover, many correctional administrators maintain that if mass screening was being undertaken, even if confidentiality could be assured, any individual might be rumored to be seropositive regardless of actual test results. The potential problem of false positives, as discussed earlier, would only add to the difficulty.

If actual or rumored test results become known to the larger correctional population, inmates may face intimidation, threats, or actual violence. If seropositives are segregated, they might be better protected than if they were maintained in the general population. It seems clear that if mass screening is to be undertaken and if seropositives are to remain in the general population, it is absolutely critical that confidentiality be preserved. Seropositive inmates housed in the general population reported in interviews that they and others had been verbally and physically abused by other inmates. (Of course, similar problems may occur in any testing program in which seropositives remain in the general population.) Moreover, disclosure of positive test results – regardless of its effects in the correctional setting – could subject inmates to serious discrimination in employment, housing, and insurability after they are released.

What Are the Legal Implications of Mass Screening?

Mandatory mass screening programs may be impossible to implement under existing laws or policies in some jurisdictions. For example, laws in California, Wisconsin, Massachusetts, New York, the District of Columbia and several other jurisdictions prohibit HIV antibody testing without the informed consent of the subject. Lawsuits may also affect policies on mandatory testing. For example, suits have been filed by inmates in a number of states demanding mandatory testing of all inmates. (See Chapter Six for a summary of this and other caselaw.) Decisions favoring the plaintiffs in such cases may create conflicts with existing state laws requiring informed consent.

There may also be a right of refusal based on ethical considerations. Those who oppose mandatory mass screening argue that because disclosure of test results can have very serious negative consequences, medical ethics require that there be a right of refusal. They liken this right to a patient's right to refuse a potentially risky surgical procedure, such as open-heart surgery. On the other hand, some correctional administrators and their legal counsel are concerned that if they fail to identify seropositive inmates through mas screening and to take strong action to prevent their transmitting the virus to others, the jurisdiction and its officials may be subject to lawsuits. Such suits might be filed by inmates or staff who may become infected with HIV and allege that the correctional system was negligent in not identifying and segregating seropositive inmates or taking other measures to prevent transmission of the virus.

Many correctional lawyers, however, point out that the two primary methods of HIV transmission – sexual contact and intravenous drug use – are already prohibited in correctional institutions, and thus it is only the victim of forced sexual activity who could bring such a claim. These lawyers believe that improved policies and procedures to prevent sexual victimization – if appropriately developed and enforced – would be sufficient to defend against a charge of negligence.

Lawyers also respond to the concern about lawsuits by noting that it is extremely difficult to establish exact causation in the development of AIDS, ARC, or HIV infection. If it is difficult to identify the specific incident responsible for transmission of the virus, it is even more difficult to prove that the system was negligent in failing to prevent that incident. (Chapter Six discusses these legal implications in greater detail.)

Correctional systems should also consider their possible liability in *falsely* labeling an inmate infected. If an inmate tested positive and was subjected to segregation, discrimination, or abuse as a result, but was retested after release and found to be negative, he or she could sue the correctional system.

A final question illustrates the legal complexities of mass screening in a correctional setting: If a correctional system institutes mass screening, citing the right of correctional officers to know the antibody status of all persons with whom they could become involved in potential transmission incident, then can inmates justifiably argue for the converse: that is, that they know the antibody status of all staff?

How Costly Are Mass Screening Programs?

While proponents argue that screening could be accomplished economically, some correctional administrators argue that such programs would be prohibitively expensive. There are really two major cost components that must be considered: the actual costs of testing, and the costs of implementing any policy decisions regarding HIV seropositive individuals. In addition, the opportunity costs – that is, the programs or functions which those funds otherwise would have supported – should be considered.

Survey results show that the ELISA test can be purchased relatively cheaply in large volume (average per test, $13, with a range of $2 to $38). The cost of the confirmatory Western Blot averages about $41 per test, with a range of $2 to $99. This adds significantly to the total cost, particularly if a large number of inmates tested positively on the ELISA. However, there may be ways to reduce the cost per test sequence. A manufacturer may offer a flat rate as low as $3 per test sequence (to include the double ELISA and Western Blot), particularly where the ELISA seropositive rate is expected to be quite low.

While the cost per test sequence may not be particularly high, critics argue that the total cost of administering tests to a large inmate population may be significant. Moreover, follow-up testing of initial negatives poses difficult problems: should the system retest to determine if seroconversion has occurred and, if so, at what intervals? Critics of mass screening argue that the need for repeat testing creates almost insurmountable logistical and cost problems, particularly for large systems.

Added to the costs of testing must be the costs of implementing any policy decision regarding seropositives. These might include construction or renovations required for separate housing units, as well as the costs of counseling, special programming, additional supervision, or other precautionary and preventive measures.

Will Mass Screening Support or Undermine the Effects of Education and Prevention Programs?

Proponents of mass screening argue that correctional systems must identify potentially infectious inmates, in order to target to maximum effect their educational and counseling programs and other preventive measures. In this view, the information is also essential to target measures for preventing the transmission of the virus after an inmate is released.

Opponents of mass screening argue that it is unnecessary and possibly counterproductive to target special educational programs and preventive measures to seropositive individuals. They believe that such targeted programs may stigmatize one class of inmates, subjecting them to potential intimidation and violence.

One state prison, suffering from serious budget limitations, planned to distribute a booklet titled "What Gay and Bisexual Men Should Know About AIDS" *only* to those inmates who had been treated for a venereal disease while incarcerated or who had been otherwise identified as engaging in homosexual activity. This plan would have clearly marked a group of inmates as gay, possibly subjecting them to victimization. Luckily, officials decided at the last minute to distribute the booklet to *all* inmates.[13]

The point is that targeted education and prevention programs might give insufficient attention to the real risks, and associated precautions, applicable to all inmates. Seronegative inmates might be considered "safe" for sexual victimization by others or they might unjustifiably consider themselves "safe" from infection and thus pay little or no attention to the recommendations of educational programs on AIDS. As already noted, a negative test says nothing of the likelihood of future infection, particularly if high-risk behaviors are continued. Thus, screening might lull seronegatives into a false sense of security and undermine the important educational message that *everyone* needs to be very careful about behaviors known to be associated with HIV transmission.

Will Mass Screening Allay or Inflame the Fears of Inmates, Staff, and the Public?

Some of those who favor mass screening suggest that the results of such programs may allay the fears of AIDS within correctional institutions more effectively than any education program. They advocate mass screening as a means of demonstrating to the general public, inmates, and correctional staff that prisons and jails are not "breeding grounds" of HIV infection and AIDS. Again, however, mass screening is not necessary to demonstate this point. The Oregon correctional system, for instance, is undertaking a *blind* epidemiological study of HIV infection in its institutions, in the hope that low seroprevalance rates will calm public concern and defuse demands for mandatory mass screening.

Of course, mass screening for public relations purposes depends on discovering low rates of HIV seropositivity. Publicizing high rates may greatly increase fear among inmates and staff. The New York City Department of Corrections has a very strong policy against mandatory mass screening. City correctional officials estimate that there are large numbers of seropositive inmates in the system. However, they note that without a mass screening program to call attention to this fact and to identify and stigmatize seropositive inmates, but with a strong educational program for all inmates and staff, there has been a minimum of fear and disruption.

In considering the public's reaction to the problem of AIDS in prisons and jails, proponents of mass screening suggest that it is the responsibility of correctional systems to know the prevalence of HIV infection in their institutions and to determine the degree to which it is being transmitted. They suggest that failure to institute mass screening may undermine the system's credibility and create a serious public relations problem. Proponents of screening are concerned that the public might criticize the correctional system for "not instituting policies that address the problem head-on" and conclude that "if they aren't testing, they must have something to hide." These views, in turn, may feed a general public perception that prisons and jails are "breeding grounds" for evils such as AIDS—a perception that correctional administrators are not eager to encourage.

Critics respond that there are better policies than mass screening for addressing the problem of AIDS in prisons and jails. They argue that the public can be convinced of this fact by judicious presentations of the risks and benefits of mass screening programs and the alternatives available to address the problem—such as blind epidemiological studies.

Is Mass Screening the Best Way to Assess the Extent of the AIDS Problem in an Inmate Population?

Proponents argue that mass screening is the best way to determine the prevalence of HIV infection and the transmission of the virus in correctional institutions. However, carefully designed epidemiological studies can provide accurate data on prevalence and transmission of HIV while avoiding some of the potential problems of mass screening. Such studies can also help to identify the epidemiological correlates of infection in the correctional setting. Finally, they can be used to project future numbers of AIDS and ARC cases and thus inform budgeting for treatment and possible facility expansion.

Epidemiological studies can be done anonymously so that no one knows who was tested, or with what results. A number of correctional systems have already undertaken or plan to undertake blind HIV prevalence studies. The results of some of these were presented in Chapter Two. In addition, the Centers for Disease Control and the National Institute of Justice are planning to sponsor a "sentinel" seroprevalence study in ten correctional systems nationwide representing a variety of inmate populations and presumed infection rates.

The most commonly recommended model for HIV transmission studies is to test an incoming cohort of inmates and to retest the same cohort at regular intervals thereafter. Anonymity can be maintained by collecting and freezing intake and followup blood samples labeled with a common study number and destroying the linkage between inmate name and study number before any testing is done. This is the approach used in a study being undertaken in the Illinois Department of Corrections under the sponsorship of CDC. Another approach is to test inmates continuously incarcerated since before the AIDS virus first appeared in the United States. This was the method used in the first Maryland study discussed in Chapter Two.

Should Correctional Systems Be Taking Steps Not Taken in Society at Large?

Mass screening clearly raises the issue of whether correctional systems should be taking steps not generally being taken in the community at large, or even in other long-term care facilities such as hospitals and mental institutions. Apart from screening donated blood and blood products, the only mass screening programs currently in progress outside corrections are the routine testing of all prospective armed forces recruits and current military personnel, and the screening of all applicants for the foreign service, all applicants for immigration to the United States and, in two states (Illinois and Louisiana), all applicants for marriage licenses.

Two arguments have been used to support screening of military personnel. First, the armed services need a "walking blood bank" that is absolutely safe in case of a combat deployment. In other words, it must be perfectly safe to obtain donated blood from any individual in order to tranfuse another. The second argument is that all military personnel must receive live vaccines against various diseases, but that immunosuppressed individuals might develop these diseases from the vaccine itself. (This argument also supports screening of foreign service applicants.) Neither of the military rationales is relevant to corrections populations. Screening of potential immigrants, while somewhat controversial, does not involve U.S. citizens or persons currently residing in this country. Premarital screening has been harshly criticized on the grounds that it will be extremely expensive, yet identify far more false positives than truly infected persons.[14]

The primary argument for mass screening in the correctional setting rests on the assumption that rates of seropositivity and of HIV transmission are likely to be higher among prison inmates than in the population at large. In this view, since rates of intravenous drug abuse among criminal offenders are higher than those of the general population, seropositivity rates among incoming inmates may be significant. There may also be opportunities for inmates to transmit the infection through sexual activity and needle-sharing

82

while incarcerated. This, proponents suggest, justifies taking unusual steps to reduce transmission. Survey responses show that ten of thirteen systems (77 percent) which have instituted mass screening consider the information "very" or "somewhat" useful in achieving their correctional management objectives.

Critics of mass screening point out that there is no evidence of higher rates of HIV transmission in correctional institutions than in the general population, and that, absent such evidence, it is dangerous and unjustifiable to apply measures to prisoners which are not applied to others. Even if mass screening, segregation and other prevention measures based on identification of seropositives could reduce transmission of HIV and facilitate medical monitoring, opponents argue, these goals can be as well achieved by education, prevention of victimization, and other less intrusive measures.[15] The decision to adopt or reject mass screening, therefore, may not really constitute a choice between pursuing legitimate public health interests and supporting the individual rights of inmates. Rather, the alternatives to mass screening may enable systems to better serve *both* of these vital interests simultaneously.

If and when therapeutic drugs such as AZT prove effective in inhibiting the development of illness in asymptomatic seropositive individuals, there may be better reason to screen inmates. However, it is unlikely that mandatory screening would be required in such circumstances, as persons who believed they might be infected would presumably flock to be tested.

Summary of NIJ Survey Results

Twelve states and the Federal Bureau of Prisons have instituted or planned mass screening of all inmates or all new inmates for antibodies to HIV. No city or county correctional systems have adopted this policy. Ten of the systems (nine states and the Federal Bureau of Prisons) now doing mass screening (77 percent) instituted the policy since the 1986 NIJ survey. As already noted, almost all of the mass screening jurisdictions are small states with few or no AIDS cases in their correctional systems. The ten jurisdictions which have adopted mass screening since 1986 cited a variety of rationales for their polices. About half cited the desire to identify HIV carriers, to target educational programs, to make better budget projections, and to respond to potential transmission incidents. About two-thirds cited improved diagnostic procedures. However, the largest number (eight of ten) cited the need to estimate the extent of the problem. (As has been discussed previously, such estimates may be more easily and economically obtained from blind epidemiological studies.) Finally, as has also been noted, almost 60 percent of these jurisdictions reported that they had been under political pressure to institute mass screening. Two systems replied that state law required mass screening of prisoners, and another reported that its mass screening policy resulted entirely from "political pressures by individuals who know nothing of the disease and are panic-stricken."

None of the five jurisdictions that collectively account for almost two-thirds of all inmate AIDS cases – New York State, New York City, New Jersey, Florida, and Texas – have implemented mass screening of inmates. Most jurisdictions, including New York State, New York City, and Florida conduct testing only when clinically indicated. New Jersey tests all pregnant females believed to be at risk (e.g., intravenous drug abusers) and inmates with clinical indications of HIV infection. No Canadian correctional systems are conducting mass screening.

HIV antibody testing occurs on a more limited basis in almost all of the jurisdictions responding to the NIJ survey. Figure 4.5 summarizes the questionnaire responses on the types of screening/testing programs currently in place or planned for the near future. The figure shows that 31 percent of state/federal systems and 27 percent of responding city/county systems screen members of at least one "risk group" regardless of whether these individuals display clinical indications. On the other hand, more systems (73 percent of state/federal systems and 45 percent of responding city/county systems in the United States) use the HIV antibody test in the presence of clinical indications. Forty percent of Canadian systems test when clinically indicated and another 40 percent do no testing at all. We believe that survey respondents may have underreported testing when clinically indicated.

Some correctional systems provide testing to any inmate on request (49 percent of state/federal systems and 55 percent of responding city/county systems in the United States). Some systems also test inmates on request if they have a history of high-risk behavior. Twenty-five percent of state/federal systems use (or plan to use) HIV antibody testing for anonymous epidemiological studies while only 9 percent of the responding city/county systems in the United States report testing for epidemiological studies. The numbers in Figure 4.5 add to more than the total number of jurisdictions responding because the policy categories shown are not mutually exclusive.

Figure 4.6 places the screening/testing policies of the responding jurisdictions into mutually exclusive categories and compares them to the 1986 results. The

Figure 4.5

SUMMARY OF RESPONDING JURISDICTIONS' POLICIES ON HIV ANTIBODY TESTING OF INMATES[a]

Policies	State/Federal Prison Systems (n = 51)		City/County Jail Systems (n = 33)		Canadian Systems (n = 12)	
	n	%	n	%	n	%
• HIV antibody screening						
– Mass screening (all or all new inmates)	13	25%	0	0%	0	0%
– Screening of "risk groups"[b]	16	31	9	27	3	25
• Testing of any inmate on request	25	49	18	55	3	25
• Testing risk-group members on request	27	53	19	58	4	33
• Testing when clinically indicated	37	73	15	45	5	42
• Testing in response to incidents	15	29	7	21	2	17
• Testing for epidemiological studies	13	25	3	9	0	0
• No testing	0	0	3	9	5	42

[a] Includes actual and planned policies.

[b] Testing identifiable inmates with histories of high-risk behavior (e.g., homosexuals, intravenous drug abusers, prostitutes), regardless of whether they display clinical indications.

major change over the past year, particularly in federal and state systems, has been the sharp rise of mass screening and the more modest increase in "risk-group" screening. Smaller percentages of correctional systems than before are limiting their testing to the presence of clinical indications. This shows that about one-half of American jurisdictions (47 percent of state/federal systems and 42 percent of responding city/county jurisdictions) in the United States and one-fourth of Canadian systems test inmates only when clinically indicated, in response to incidents, or in support of blind epidemiological studies. In 4 percent of state/federal systems, 24 percent of responding city/county jurisdictions and 8 percent of Canadian systems, testing is conducted only on a voluntary basis or on request. One-fourth of the state/federal systems, but no city/county systems and no Canadian systems, make HIV antibody testing of inmates mandatory. As discussed above, these decisions may be guided in large measure by law, policy, and ethical considerations. In several jurisdictions, including Iowa, inmates may refuse to be tested, but if they do so, they are placed in segregation until they will submit to the test.

Virtually all (88 percent) of the state/federal correctional systems employ the double ELISA test with confirmation by Western Blot. However, only about half of city/county and Canadian systems that do HIV testing reported using this standard test sequence recommended by CDC. Many jurisdictions reported uncertainty as to the exact testing protocol used. Several others indicated that the protocol varied across the system. This variability could mean potential problems with testing quality control and accuracy.

The following sections describe some of the other applications of HIV antibody testing being used in the responding jurisdictions.

Other Applications of HIV Antibody Tests

This section discusses other correctional applications of the HIV antibody test besides mass screening. These

Figure 4.6

MUTUALLY EXCLUSIVE CATEGORIZATION OF RESPONDING JURISDICTIONS' SCREENING/TESTING POLICIES FOR INMATES[a]

	State/Federal Prison Systems (n = 51)				City/County Jail Systems (n = 33)				Canadian Systems (n = 12)	
	Second Survey: October 1986		Third Survey: October 1987		Second Survey: October 1986		Third Survey: October 1987		October 1987	
Policy Category	n	%	n	%	n	%	n	%	n	%
• Mass Screening (all or all new inmates	3	6%	13	25%	0	0%	0	0%	0	0%
• Screening of "Risk Groups" (including pregnant women) but not mass screening	11	22	12	24	6	18	9	27	3	25
• Testing *only* in Clinical Indications, Incident Response or Epidemiological Studies	30	59	24	47	14	42	13	39	3	25
• Testing *only* on Inmate request	1	2	1	2	4	12	7	21	1	8
• Testing only voluntary			1	2	0	0	1	3	0	0
• No Testing	6	12	0	0	7	21	3	9	5	42
• No Update	0	0	0	0	2	6	0	0	0	0
TOTAL	51	101%[b]	51	100%	33	99%[b]	33	99%[b]	12	100%

---

[a] Includes actual and planned policies. This is a hierarchical categorization. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that screen identifiable inmates with histories of high-risk behaviors, but no mass screening, are placed in the "screening risk groups" category regardless of whether they also do testing for diagnosis, incident response, or epidemiological studies.

[b] Due to rounding.

include risk-group screening, testing in response to incidents in which transmission of HIV may have occurred, voluntary testing, testing on inmate request, testing in support of blind epidemiological studies, and testing of correctional staff.

Testing Inmates with Histories of High-Risk Behavior

A number of states have begun screening inmates with histories of high-risk behavior as an alternative to mass screening. However, it may be very difficult to define the groups to be tested and to identify all their members with certainty. Moreover, since AIDS is a disease of high-risk behaviors rather than high-risk groups, "risk-group" screening may not succeed in identifying all or even most of the infected individuals.

The most commonly defined "risk groups" for AIDS or ARC are intravenous drug abusers, homosexual and bisexual men, and certain pregnant women. In some jurisdictions it would be difficult to define a set of "risk groups" that did not collectively cover virtually all inmates in the system. If this is the case, "risk group" screening in effect becomes screening of all inmates, with the concomitant stigmatization and other ill effects for large segments of the inmate population. Indeed, any screening of groups, however designed, may have negative effects for all members of such groups.

The question of whether to test pregnant women, or even all women of childbearing age, has arisen because of the possibility of perinatal transmission of the AIDS virus. CDC has recently recommended that all pregnant women and all women of childbearing age with identifiable risks for HIV infection be counseled and routinely tested for antibodies to HIV ("routine" testing means testing unless the subject declines).[16] Several systems now test all pregnant women inmates.

Finally, in response to concerns about AIDS, many jurisdictions have eliminated plasmaphoresis programs or prohibited inmates from donating blood. In states that have maintained their plasmaphoresis programs, all inmate participants must be tested. This is clearly an absolute requirement rather than an option, because of the very real public health and legal liability concerns regarding the blood supply.

Testing in Response to Potential Transmission Incidents

Individuals may be tested if they are involved in a particular incident in which exposure may have occurred. In correctional institutions, such incidents include needlesticks or other sharp instrument injuries, forcible rapes, biting incidents, and other situations in which there may have been blood-to-blood contact or exposure to other bodily fluids of individuals known or suspected to be infected with HIV.

Correctional systems' policies in these instances vary considerably. The major issue seems to be whether inmates can be *required* to undergo testing if they have been involved in an incident. Forty-three percent of state/federal correctional systems, 24 percent of city/county systems, and only 8 percent of Canadian systems believe that they can require testing of individuals involved in incidents. Texas requires testing of inmates who commit sexual assault, throw blood or body fluids at staff or otherwise intentionally or accidentally expose staff to blood or body fluids. Inmates who refuse to be tested are treated as if they were HIV seropositive.[17] Georgia has adopted a comprehensive policy recommending (but not mandating) testing in certain situations. (This policy is included in Appendix G.) Some correctional systems, including New Mexico's, believe that they will be able to obtain a court order requiring an inmate to undergo testing following a potential transmission incident. However, laws in a number of states currently prohibit HIV antibody testing and/or prohibit disclosure of test results without informed consent. Cases have already been decided with reference to these laws, as well as to the probability of transmission in particular incidents. It is possible that at least some of these laws will soon be modified to permit involuntary testing and disclosure of test results of persons who commit aggressive acts which might transmit HIV. A law requiring testing of inmates who bite, cause exchange of bodily fluids, or throw any bodily secretion on another person has recently been passed in Iowa.[18] (See Chapter Six for further discussion of these legal issues.)

If testing is to be done at all, it is generally agreed that individuals involved in incidents should be tested immediately to determine whether or not they were seropositive at the time of the incident. If so, they obviously could not seroconvert as a result of the incident. Follow-up testing on initial negatives may be performed at three-month intervals after the incident, as it generally takes three-twelve weeks following infection for the antibodies to appear.

Voluntary Testing

In voluntary testing programs, the correctional system may request or recommend that all or certain inmates be tested, but the system cannot or will not attempt to compel cooperation. In Montgomery County, Maryland, for example, all inmates with histories of high-risk behavior are requested to submit to the antibody test, but no testing is performed without informed consent. Texas also offers testing to such inmates on a voluntary basis. The Massachusetts Sheriffs' Association recently recommended that all the state's county houses of correction offer all inmates testing on a voluntary basis with strict assurance of confidentiality.[19] Wyoming and San Bernardino County (California) conduct testing only on a voluntary basis.

There can be forms of coercion, such as threats of segregation, applied even in ostensibly voluntary testing programs. The former director of New York City's Montefiore Medical Center/Rikers Island Health Services emphasizes that no one should be coerced or pressured into being tested and urges that the anonymity of anyone who is tested should be assured by using alternative test sites.

Informed consent should be obtained using a form that clearly lays out all the implications of being tested, including an enumeration of those entitled to receive the results, a realistic assessment of the possibility that confidentiality may be breached, and a statement of the likelihood that special housing or programming will be necessary for seropositive individuals. A consent form used in Wisconsin is included in Appendix H. The Wisconsin form is quite good, although it may be somewhat too optimistic regarding the likelihood that the results will remain confidential.

In addition, inmates should be clearly advised of the possible negative effects of test results on their ability to obtain housing, employment, and insurance after they are discharged. This should constitute a part of standard pre-test counseling.

Testing on Request

About one-half of responding American correctional systems provide testing to inmates on request. Two important questions arise here. First, do correctional systems have a legal obligation to provide testing on request? And, second, is anyone entitled to testing on request, or only those with a supportable reason for desiring the test (e.g., involvement in an incident, history of high-risk behavior, or presence of symptoms)? There are no conclusive answers to these questions, although pending lawsuits in several states will undoubtedly clarify the issues. In the meantime, policies differ. Maine, for instance, will provide up to two requested, but "not medically indicated," tests per year. Texas will provide only one such test per year.[20]

Notably, there may already be an important precedent in *Estelle v. Gamble*,[21] one of the leading cases on correctional health care standards. While this decision establishes that correctional systems have an obligation to respond to the medical needs of inmates, it does not give inmates the right to dictate the quantity or quality of the medical care provided. According to *Estelle*, this must remain a medical decision. This seems to support the position that correctional systems could deny HIV antibody tests to inmates at least where there were no apparent clinical indications or other legitimate reasons for testing.

Another issue affecting testing on request is the type of counseling that is provided both before and after the test is administered. In Utah, any inmate who requests testing is advised that the state health department will be informed of the results, that any seropositive inmate can expect stringent administrative sanctions for engaging in intravenous drug use or homosexual activity, and that seropositive inmates may be assigned to special housing units. As discussed above, inmates should be counseled regarding the potential personal and psychological costs, as well as the potential benefits, of being tested.

Testing in Support of Epidemiological Studies

As indicated earlier in this chapter, blind epidemiological studies may represent a useful (and less costly) alternative to mass screening for determining rates of HIV infection and assessing the extent of HIV transmission in institutions. These studies can be designed so that test results are never linked to individual inmates. Such studies have already been conducted in a number of correctional systems, and others plan to undertake them in the near future.

Testing of Correctional Staff

Virtually all of the screening and testing programs identified in NIJ survey responses involved inmates. Most correctional systems have no involvement in the medical care of staff. In such jurisdictions, any testing of staff is strictly a matter between the staff member and his or her personal health care provider.

Proposals to screen all prospective correctional officers are highly questionable on ethical and legal grounds. Asymptomatic HIV infection certainly does not preclude satisfactory job performance and the likelihood of transmission on the job is extremely remote.

Some systems did report that they would test staff members who had been involved in incidents during which transmission of the AIDS virus might have occurred. As already noted, Hennepin County (Minneapolis) Minnesota tested six correctional officers who had been involved in such incidents. Finally, several systems noted that they would offer antibody testing to staff under other circumstances—if, for instance, they experienced symptoms of ARC or AIDS. In Michigan, the correctional officers union obtained a commitment from the state that any staff member would be provided an antibody test on request.

Who Receives Test Results?

The important and complex issue of who is notified of inmates' HIV antibody test results is discussed in Chapter Six, as part of an overall discussion on confidentiality and disclosure of AIDS-related medical information.

Conclusion

This chapter has discussed the major applications of HIV antibody testing in the correctional setting and the perceived advantages and disadvantages of the range of testing options open to correctional administrators. The most controversial testing application is mass screening of inmates in the absence of clinical indications. In the correctional setting, we define mass screening as the mandatory testing of all inmates or all new inmates.

There are a variety of possible applications for the antibody test besides mandatory mass screening. These include screening inmates with histories of high-risk behavior, testing in response to incidents in which transmission of the virus may have occurred, voluntary testing, testing on request, and testing in support of epidemiological studies. Finally, correctional systems rarely become involved in staff testing, except perhaps in response to possible transmission incidents. Proposals to screen all prospective staff members for antibodies to HIV are highly questionable, both legally and ethically.

Twelve state correctional systems have implemented or are planning to implement mass screening programs for inmates; no city or county systems have instituted or planned such programs for inmates. The Federal Bureau of Prisons tests all inmates on release and a 10 percent random sample of incoming inmates. However, almost all of the jurisdictions responding to the survey do employ testing for more limited purposes, such as when clinically indicated or when requested.

The issue of mass screening for antibodies to HIV in correctional institutions has sparked an intense debate, involving the following major questions:

Are HIV Antibody Tests Reliable and Accurate?

Proponents of mass screening argue that the available tests are highly reliable and accurate, with very few false positive and negative results.

Opponents point out that there continue to be serious concerns about false positives, particularly in populations with low true rates of infection (which include most correctional populations in the United States and Canada). False negatives, resulting from the lag-time between infection and appearance of detectable antibodies as well as from technical problems with the tests, may also be a problem, particularly in populations with higher true infection rates. The accuracy problems apply even when the basic ELISA test is repeated and confirmed with a Western Blot.

Can Mass Screening Prevent Transmission of HIV?

Proponents argue that mass screening facilitates policies that will reduce transmission of HIV in correctional facilities, such as special housing, supervision, counseling, and educational programs. In addition, they suggest, staff need to know which inmates are infected in order to take special precautions with them.

Opponents reply that it is better to focus prevention and classification strategies on inmates likely to be predatory (perhaps transmitting infection through forced sexual activity) or otherwise prone to high-risk behaviors, rather than trying to identify all infected inmates, many of whom may not pose behavioral problems. Indeed, knowledge of positive antibody status may prompt behavior problems. With regard to staff, critics of mass screening argue that universal precautions should be applied and that knowledge of inmates' antibody status might lead to dangerously careless double standards of precaution.

Will Mass Screening Improve Medical Monitoring and Care?

Proponents suggest that identifying seropositives will facilitate timely medical monitoring and diagnosis and cost-effectively focus intervention on those inmates most likely to be in need of such services.

Opponents argue that it is unfair to subject seropositives to inevitable stigma when there is no cure available, and that there are reasonable alternatives for the proactive identification of inmates at high risk for HIV infection. These include careful history-taking, surveillance and diagnostic procedures using other tests which can identify immuno-suppression.

Is It Possible to Maintain the Confidentiality of Antibody Test Results in Correctional Facilities and How Does Disclosure of Results Affect Seropositive Inmates?

Proponents of mass screening argue that confidentiality can be maintained by keeping test results out of inmate medical records and carefully controlling access to any lists of seropositive inmates.

Opponents argue that confidentiality of such sensitive information is impossible to maintain in a correctional setting, and that disclosure of test results as well as circulation of unfounded rumors regarding inmates' antibody status will inevitably lead to ostracism, verbal intimidation, and possibly serious physical violence. Disclosure of results could also lead to serious discrimination following discharge.

What are the Legal Implications of Mass Screening?

Proponents argue that mass screening is legal and proper and that failure to identify potentially infectious inmates could raise serious liability problems for the correctional system.

Opponents argue that mass screening is illegal in many jurisdictions and that any legal liabilities could be effectively addressed by better procedures for the prevention of sexual victimization.

How Costly are Mass Screening Programs?

Proponents argue that systems can implement screening quite economically by buying test kits or laboratory services on a high-volume basis.

Opponents respond that costs may be very high, particularly when periodic followup testing of seronegatives and separate housing and programming for seropositives are considered.

Will Mass Screening Support or Undermine the Effects of Education and Prevention Programs?

Proponents of mass screening argue that potentially infectious inmates must be identified so that they may be targeted in education and prevention programs.

Critics respond that such differential education and prevention programs needlessly stigmatize one group of inmates while perhaps lulling the others into a false sense of security. In fact, everyone should receive the same educational messages regarding high-risk behaviors.

Will Mass Screening Allay or Inflame the Fears of Inmates, Staff, and the Public?

Proponents suggest that mass screening could help to calm the concerns of inmates, staff, and the public if low rates of seropositivity were found. Moreover, failure to screen might indicate to the public that the system was failing to address the problem of AIDS in its facilities.

Critics contend that mass screening will needlessly inflame fears, particularly if seropositivity rates are found to be high.

Is Mass Screening the Best Way to Assess the Extent of the AIDS Problem in an Inmate Population?

Proponents argue that mass screening is the best way to determine the scope of the problem and is necessary to inform key budgetary and facility planning decisions.

Critics reply that the same information can be obtained from blind epidemiological studies in which test results are not linked with individual inmates, thus avoiding the inevitable stigmatization and ostracism of identified and rumored seropositives.

Should Correctional Systems be Taking Steps Not Taken in Society at Large?

Proponents contend that presumed high rates of infection with and transmission of HIV in correctional facilities justify the mandatory mass screening of inmates.

Critics respond that infection rates are low in many correctional populations and that available evidence also suggests low rates of HIV transmission among inmates. Even if screening would produce some reduction in transmission and some improvement in medical management, opponents emphasize, the same effects can be achieved by education, aggressive efforts to prevent victimization, and other, less broadly intrusive measures. In short, the decision whether to adopt or reject mass screening may not really pose a dilemma between public health considerations and individual rights. Rather, the alternatives to mass screening may better serve *both* vital interests simultaneously.

Decisions about whether or not to institute mass screening should be based on careful consideration of these issues, rather than on the political pressure that has arisen on the subject.

89

Notes

1. McCombie, S.C., "The Cultural Impact of the 'AIDS' Test: The American Experience," *Social Science and Medicine* 1986; 23:455-459.

2. CDC, "Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS," *MMWR*, August 14, 1987; 36:509-515.

3. A. Ranki et al., "Long Latency Precedes Overt Seroconversion in Sexually Transmitted HIV Infection," *The Lancet*, September 12, 1987; 2:589-593.

4. Michael J. Barry et al., "Screening for HIV Infection: Risks, Benefits, and the Burden of Proof," *Law, Medicine and Health Care*, December 1986; 14:259-267.

5. J. Morgan et al., "Potential Source of Error in HTLV-III Antibody Testing" (letter), *The Lancet*, 1986; 1:739-740; I. Cayzer and S. Field, "Elimination of Source of Error in HTLV-III Antibody Testing" (letter), *The Lancet*, 1986; 1:1032-1033.

6. Barry, "Screening for HIV Infection."

7. CDC, "Update: Serologic Testing for Antibody to HIV," *MMWR*, January 8, 1988; 36:833-840, 845.

8. Barry, "Screening for HIV Infection"; K.B. Meyer and S.G. Pauker, "Screening for HIV: Can We Afford the False Positive Rate?" *New England Journal of Medicine*, July 23, 1987; 317:238-241.

9. Michael Specter, "Some Inmates with AIDS Virus to be Isolated," *Washington Post*, October 24, 1987, p. A14.

10. Barry, "Screening for HIV Infection."

11. Barry, "Screening for HIV Infection"; R. D'Aguila et al., "Prevalence of HTLV-III Infection Among New Haven, Connecticut Parenteral Drug Abusers in 1982-1983" (letter), *New England Journal of Medicine*, January 9, 1986; 314:117-118; Zafar, N.Z., "Screening for Antibodies to HTLV-III/LAV in our Population: A Word of Caution," *Journal of the Pakistani Medical Association*, April 1987; 37:84-85

12. L.O. Gostin, W.J. Curran, and M.E. Clark, "The Case Against Compulsory Casefinding in Controlling AIDS-Testing, Screening, and Reporting," *American Journal of Law and Medicine*, 1987; 12:43.

13. Shuman, H.I., "AIDS Inmates and HIV Screening: A Rational Approach to AIDS in Correctional Institutions," (unpublished paper, November 1987). Dr. Shuman is Regional Health Services Director, Florida Department of Corrections, Region V, Tampa, Florida.

14. P.D. Cleary, et al., "Compulsory Premarital Screening for HIV," *Journal of the American Medical Association*, October 2, 1987; 258:1757-1762.

15. The same conclusion is reached in Gostin et al., "The Case Against Compulsory Casefinding," p. 39-45. This, and another article (Bayer, R. et al., "HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs," *Journal of the American Medical Association*, October 3, 1986; 256:1768-1774) provide useful sets of criteria for decisions regarding mandatory mass screening.

16. CDC, "Public Health Service Guidelines for Counselling and Antibody Testing to Prevent HIV Infection and AIDS," *MMWR*, August 14, 1987; 36:512.

17. Texas Department of Corrections, Manual of Policies and Procedures for Health Services, No. 3-39, October 1987, p.6.

18. Lewis, H.E., "AIDS: State Legislative Activity," *Journal of the American Medical Association*, November 6, 1987; 258:2410-2414.

19. Massachusetts Sheriffs Association, "Report of the Massachusetts Sheriffs' Association Task Force on AIDS in County Correctional Facilities," (June 25, 1987).

20. Maine Department of Corrections Contingency Plan, #2 for Testing for HIV Antibodies, September 1, 1987; Texas Department of Corrections Manual of Policies and Procedures for Health Services, No. 3-39, October 1987, p.5.

21. 429 U.S. 97 (1976).

Chapter 5: Medical, Psycho-Social and Correctional Management Issues

This chapter discusses four key facets of the policy response to HIV infection and AIDS in correctional settings: medical care; counseling and psycho-social services; housing decisions; and precautionary and preventive measures.

Ironically, medical care—as complex as it is—may be the simplest issue confronting correctional administrators. It is the related correctional management issues—where to house and treat the inmate, how to prevent the spread of the infection and how to pay for medical care—that may be the most difficult to resolve. In this chapter, we examine many of the ways that correctional administrators have responded to these institutional management issues, and we explore some of the advantages and disadvantages of these approaches.

Medical and Psycho-Social Services

Perhaps the highest priority in the correctional response to AIDS is providing timely, professional and quality medical care to inmates who become ill with the disease. However, effective medical care must not be simply reactive; it must also include programs for the timely detection, diagnosis and regular surveillance of the full spectrum of reactions to HIV infection. When responding to the challenging problem of AIDS in prisons and jails, administrators must deal with not only the difficult medical issues; they must also balance medical considerations and medical advice against complex correctional management factors. Where medical guidelines and correctional considerations are at odds, difficult decisions must be made in an effort to satisfy both interests to the maximum extent.

Detection, Diagnosis and Medical Surveillance

The basic medical issues posed by AIDS are identical within and outside the correctional institution. Prompt detection and diagnosis are vital to develop the best treatment plan for each patient. HIV antibody tests may be used in support of screening and diagnosis efforts, although, as already discussed, they raise many controversial medical, ethical, legal, and correctional management issues. Whether or not antibody testing is used, however, appropriate diagnostic workups (including complete blood count, other blood work, and anergy screens) are necessary to identify immunosuppression, ARC and AIDS.

There are also certain tests that may be able to detect early evidence of opportunistic infections typically seen in AIDS patients (e.g., the gallium scan for detecting early *Pneumocystis carinii* pneumonia).

A complete physical examination and history-taking at intake and regular physicals thereafter are key elements of the effort to diagnose HIV infection on a timely basis. Maryland, North Carolina, Iowa, and other jurisdictions have incorporated specific questions regarding symptoms of HIV-related illness and high-risk behaviors in their intake medical screening protocol. (Examples of these forms are included in Appendix F.) This facilitates identification and monitoring of inmates who may be experiencing symptoms of HIV infection and of those who may be at particular risk for infection. Illinois has a particularly aggressive intake screening program which it uses to generate a list of inmates at apparent high risk for HIV infection.[1] Some physicians in correctional systems believe that attempts to identify inmates at risk for infection constitute "labeling" which may focus undue attention on "risk groups" and detract attention from surveillance for clinical signs and symptoms of infection among *all* inmates.

Careful surveillance and regular follow-up are extremely important for patients with AIDS, ARC and asymptomatic HIV infection because serious, life-threatening symptoms can develop very quickly. Many correctional agencies have specific protocols for regular follow-up and medical surveillance. For example, Texas and Indiana conduct monthly follow-up on all seropositive inmates, while Illinois monitors all inmates on its "high-risk list" through white blood counts and physical examinations every three months. In the San Francisco County Jail, medical staff monitor pregnant women particularly closely because of the risk of perinatal transmission. They are routinely offered counseling and anonymous HIV antibody testing. The details of these protocols may vary, but their basic intent is the same: to facilitate timely medical intervention.

Some inmates may be afraid to seek medical attention for fear of being stigmatized, or they may be in a psychological denial phase. In such instances, correctional officers and other inmates can be valuable allies in the surveillance process by being watchful for symptoms and any other signs of illness.

Some correctional systems, including New Jersey's, believe that it is extremely important to maintain a centralized diagnosis and evaluation function for all inmates suspected of having ARC or AIDS. Inconsistent theories or practice regarding diagnosis and treatment could create confusion, fueling the fears of staff and inmates. New Jersey administrators emphasize that "telling a consistent story" and "using a common vocabulary" are critical to an effective strategy for managing the AIDS problem within correctional institutions.

Medical Treatment

The nature of medical treatment will depend on the inmate's health as well as on the medical capabilities available to the correctional system. Many asymptomatic inmates and those with ARC require only routine monitoring of their health status. However, inmates with extreme manifestations of AIDS almost invariably require intensive medical treatment, either within the correctional system's medical facilities or in a community hospital.

The former director of Montefiore Medical Center/Rikers Island Health Services in New York City suggests that inmates be made eligible for clinical trials of innovative AIDS treatments. This would require a "compassionate exception" to the federal regulations restricting human experimentation with prison inmates.

AZT and other therapeutic drugs that become available should be made available to correctional inmates when medically indicated. Indeed, since AZT has now been approved by the Food and Drug Administration, it *cannot legally be withheld* from patients meeting the clinical criteria. However, because AZT is extremely expensive, numerous correctional systems note that provision of the drug is becoming a major cost issue. It is not only the cost of the drug itself, but also the labor-intensive, around-the-clock schedule of administration, which pose potential problems of cost and logistics. New York state offers AZT to all inmates who meet the medical criteria for the drug—none have been denied the medication due to budget limitations. However, in some other systems, financial constraints have meant that AZT could be offered to only a limited number of qualified inmates. This policy poses serious legal and ethical issues.

Correctional systems with relatively large numbers of inmate AIDS cases, such as New York and California, have established discrete housing and treatment units. The head nurse and other staff of the AIDS unit at the California Correctional Medical Facility, Vacaville, have been able to establish a supportive atmosphere for the inmates there.

One of New York's AIDS units is in the infirmary at the Sing Sing Correctional Facility. Here, dedicated medical staff and inmate nurse-assistants have also developed a remarkably caring environment for inmates with AIDS. Every effort is made to treat the inmates with humanity and sensitivity and to provide them with as much comfort as possible, given the inevitable limitations of a correctional setting. At the Sing Sing unit, authorities deliberately avoided a closed-cell configuration which might promote feelings of isolation and persecution, deciding instead on an open ward to encourage camaraderie and mutual assistance among the inmate patients. While there have been difficulties with particular inmates, overall, the unit has been remarkably successful. Staff note that inmates often arrive in very bad medical condition, but many go into remission for long periods in the supportive atmosphere of the Sing Sing unit.

Counseling and Other Psycho-Social Services

AIDS may present extremely serious psychological problems for those with the disease. Therefore, counseling and support systems are also an important component of care. Since AIDS is a fatal disease, persons with AIDS (and those who care for them) should receive counseling on death and dying. Staff at the California Correctional Medical Facility, for example, have worked closely with associates of a leading authority on death and dying, Elizabeth Kubler-Ross, in order to develop knowledge and sensitivity in this area.

Many other areas should also be addressed in a comprehensive program of psycho-social services for inmates with AIDS and HIV infection. For example, persons with AIDS may need support in informing their parents of their homosexuality and/or IV drug use, informing their sexual partners that they are infected, or informing friends and neighbors of their illness. Counselors may also need to help HIV-infected inmates deal with denial of their illness, suicide issues, feelings of guilt and responsibility, or anger and rage at their disease. Since persons with AIDS need hope, counselors should provide help in gaining access to experimental drugs. Inmates with AIDS may require assistance with unfinished business, such as debts and wills. Finally, decisions should be made regarding the use of resuscitators or other "heroic measures" for those facing imminent death.[2]

Minnesota and Texas have responded to the need for comprehensive psycho-social services by establishing support teams for each inmate with AIDS, ARC and asymptomatic HIV infection. In Minnesota the team includes a psychiatrist, psychologist, nurse, chaplain, patient advocate, family member, and correctional counselor. Connecticut's correctional system makes social and psychiatric services, including support groups, available to AIDS patients.

The Forensic AIDS Project of the San Francisco Department of Public Health provides the following services in the San Francisco jail system: individual therapy; pastoral counseling; counseling for family members; and support groups for persons with AIDS, HIV seropositives, family members, and those who have lost persons close to them to AIDS. Finally, a promising AIDS support group has been initiated at a state prison in Georgia. This group has both helped to address and ease the personal difficulties of inmates with AIDS and ARC and raised the general level of information and awareness regarding AIDS among inmates and staff. It thus serves not only to enhance care for inmates with AIDS and ARC, but also to supplement educational programs.[3]

Because of the painful uncertainties involved, counseling may be just as important for HIV seropositives and persons with ARC as for those with end-stage AIDS. Most jurisdictions provide such counseling to affected inmates. In addition, it is important to counsel potentially infected persons regarding the risks of transmitting the infection and the means to prevent transmission.

Pre- and post-test counseling for persons undergoing HIV antibody testing are also extremely important. CDC has published guidelines for this counseling, which are included in Appendix E.[4] The American Red Cross and several states have developed question-and-answer flyers for those being tested for antibodies to HIV. These flyers discuss the meaning of the test and its implications for the individual's future behavior. The Red Cross pamphlet is for individuals with positive tests. The Oregon state Health Division has developed two separate pamphlets for counseling those who have been tested: one for risk-group members with negative tests and the other for all persons with positive tests. Finally, North Carolina has an extensive checklist of required messages and guidance for all inmates with positive tests. All of these items must be discussed with the inmates both when they are notified of test results and prior to discharge. (These materials are included in Appendix D.)

Finally, the "worried well" and those who are afraid of AIDS need counseling and support. In San Francisco, the Forensic AIDS Project conducts support groups for the "worried well" in the county jails while in Chicago, mental health specialists provide individual and group counseling to jail inmates. This counseling has been very effective in reducing fear and hostility toward persons with AIDS.

Pre-Release Planning and Aftercare

Inmates with AIDS , ARC, or asymptomatic HIV infection who are about to be released into the community require important services as well. First, they need intensive counseling on their responsibilities to notify their sexual partners of their medical status and to avoid any behaviors that may transmit infection to others. This is, of course, most critical for those with asymptomatic infection and those whose conditions will not be readily apparent. (Issues regarding the correctional system's possible responsibility for notification are discussed in Chapter Six.)

Second, pre-release planning should include identification of and referral to all government benefit programs for which the inmate may be eligible—such as Medicaid and Supplemental Security Income (SSI). In addition, of course, pre-releasees should be referred to appropriate sources of hospice care, hospitalization, outpatient care, counseling and other support services in the community. While the correctional system is not responsible for the actual provision or financing of these services, it should ensure that the former inmate has all the information necessary to obtain them. Correctional systems should never release inmates with HIV infection or AIDS without providing comprehensive pre-release planning. North Carolina has contracted with a family nurse practitioner who specializes in pre-release planning for inmates with AIDS. According to the Department of Corrections, this has been an effective arrangement.

Costs of Care and Associated Services

Responses to all three NIJ surveys show that correctional systems are almost universally concerned about the costs of medical care and associated services for inmates with AIDS. However, there are widely varying estimates of the costs of medical care both within and outside correctional systems.[5]

Average reported costs of caring for an AIDS case *inside* the correctional system ranged from $10,000 (Florida and Maryland) to $50,000 for (Illinois), while average costs for care *outside* the system ranged from $15,000 (South Carolina) to $152,000 (Rhode Island). These figures should be cautiously considered, however, since some are simply estimates and others are based on one or very few cases. Obviously, costs can differ dramatically depending on individual patient circumstances.

The only agreement seems to be that medical care for AIDS patients is expensive, whether it is provided in a correctional medical facility, in another public medical facility, or in a hospital in the community. The problem is exacerbated because medical services provided to correctional inmates may not be reimbursed under Medicaid.

Since the early years of the AIDS epidemic, several factors have dramatically affected the costs of medical care. First, as they learned more about the disease, physicians came to rely less on extended hospitalization and to shift more treatment to an outpatient basis. This both reduced the cost and seemed better for the patient psychologically. San Francisco has pioneered innovative case management strategies for persons with AIDS, which include extensive outpatient, in-home, and hospice care services, the combination of which has substantially reduced costs of care. Of course, some of these treatment modalities are not feasible for correctional inmates, but substantial cost savings can still be realized in this setting. For example, in 1985, Maryland reported its annual cost of hospitalization per inmate with AIDS to be $143,000; in 1987, that figure has been reduced to $10,000.

On the other hand, the advent of AZT therapy—priced at about $10,000 per year per inmate, plus a highly labor-intensive administration schedule—portends cost increases. Indeed, as noted, many correctional systems cite AZT therapy as a major cost concern.

In general, as indicated above, the costs of care will probably be higher if inmates are placed in hospitals in the community than if they are retained in correctional medical facilities or other public medical facilities.[6] However, a number of factors besides cost will inform decisions on where to place inmates with AIDS. These include availability and location of necessary medical care facilities, numbers of inmates in the system who require such care, and institutional security and management issues.

To the figures for hospitalization—which include all hospital and surgical charges, physicians' services, laboratory fees, and costs of prescription drugs—must be added costs of ancillary services such as counseling, possible legal advice, increased insurance (unless the system is self-insured), and funeral arrangements. Obviously, the total costs of medical care and associated services for inmates with AIDS could have serious budgetary implications for correctional systems.

In view of the high cost involved, correctional systems should develop as much information as they can, through epidemiological studies (as recommended earlier in this report) and other means, to project their future numbers of AIDS cases. Such projections will at least help administrators prepare timely requests for budgets to cover the costs of medical care and associated services for those inmates.

Housing Policies for Inmates with AIDS, ARC, or Asymptomatic HIV Infection

Deciding where to house and treat inmates who have AIDS, ARC, or asymptomatic HIV infection is one of the most critical and difficult decisions for correctional administrators. Housing decisions may be closely tied to policies regarding HIV antibody testing. For example, if a correctional system has a policy of mandatory screening, then this may lead to a decision to segregate, or otherwise separately house, inmates found to be antibody positive.

Medical considerations as well as correctional management considerations should both figure prominently in housing decisions. Most jurisdictions place inmates with confirmed diagnoses of AIDS in a hospital or infirmary setting, although the duration of such hospitalization varies considerably depending on clinical circumstances. In addition, preventing the spread of HIV infection within the facility and protecting affected inmates may also be important considerations in decisions to separate inmates with AIDS from the general population. Finally, the costs of care, availability and location of facilities able to provide appropriate care, costs of any new construction or renovations necessary to prepare special units, and staffing of any special AIDS units (correctional as well as medical) will all affect correctional decisions on treatment and housing.

Correctional administrators have a number of options concerning treatment and housing placements for inmates with AIDS, ARC, or asymptomatic HIV infection.

1. maintaining inmates in the general population with no restrictions or special programming;
2. maintaining inmates in the general population with special programming or restrictions;
3. hospitalizing inmates;
4. administratively segregating inmates in a separate unit;

Figure 5.1

HOUSING POLICIES FOR INMATES WITH AIDS, ARC, AND ASYMPTOMATIC HIV INFECTION: STATE AND FEDERAL PRISON SYSTEMS (n = 51)[a]

	Jurisdictions Following this Policy for:					
	AIDS		ARC		Asymptomatic HIV Infection	
Policy	n	%	n	%	n	%
• Maintain in general population	2	4%	11	22%	23	45%
• Maintain in general population with special programming[b]	5	10	15	8	13	25
• Hospitalization (within or outside correctional system)	29	57	9	69	7	14
• Administrative segregation/separation[c]	9	18	5	10	6	12
• Unspecified segregation/separation	3	6	1	2	0	0
• Case-by-case determination	27	53	29	57	17	33

---

[a] This includes hypothetical policies in jurisdictions that as yet have no cases in a particular category.

[b] This category includes single-celling.

[c] This category includes housing inmates in medical units for administrative reasons. This policy is generally intended to protect affected inmates from other inmates and/or to facilitate their supervision.

5. returning inmates to the general population when their illnesses are in remission; and
6. case-by-case determination of all housing and treatment decisions.

Overview of NIJ Survey Results

Figures 5.1 - 5.3 summarize responses to the NIJ survey from federal and state systems (Figure 5.1), city and county systems (Figure 5.2) and Canadian systems (Figure 5.3) regarding the housing of inmates with AIDS, ARC, and asymptomatic HIV infection. Readers should note that the policy tabulations in Figures 5.1 - 5.3 are *not* mutually exclusive. For example, a jurisdiction's basic policy may be to maintain asymptomatic seropositives and inmates with ARC in the general population, but segregate them, if medical, behavioral, or security considerations arise. Such policies would be included under both "maintain in general population" and "case-by-case determination" in Figures 5.1 - 5.3. Conversely, jurisdictions whose basic policy is to hospitalize AIDS cases but return them to the general population if they go into remission, would be included both under "hospitalization" and "case-by-case determination."

Figures 5.1 - 5.3 reflect a broad diversity of policies, although more jurisdictions have adopted case-by-case decision-making than was true in past years. Most systems still hospitalize or segregate inmates with AIDS; 81 percent of state and federal systems, and 58 percent of city and county systems have this policy. Most systems also maintain asymptomatically infected inmates in the general population, with or without special programming. This is the policy in 70 percent of state and federal systems, and 66 percent of city and county systems. Canadian systems also have diverse policies, but most have adopted case-by-case decision-making.

Figure 5.4 further summarizes housing policies according to mutually exclusive combinations and shows how these policy combinations have changed since the original survey was taken in 1985. This attempts to capture the *basic* policy followed by each jurisdiction for each category of inmate. Figure 5.4 also reflects a significant lack of consensus but it definitely confirms the trend away from blanket segregation policies toward case-by-case decision-making. Most jurisdic-

Figure 5.2

HOUSING POLICIES FOR INMATES WITH AIDS, ARC, AND ASYMPTOMATIC HIV INFECTION: CITY AND COUNTY JAIL SYSTEMS (n = 33)[a]

	Jurisdictions Following this Policy for:					
	AIDS		ARC		Asymptomatic HIV Infection	
Policy	n	%	n	%	n	%
• Maintain in general population	4	12%	7	21%	13	39%
• Maintain in general population with special programming[b]	5	15	7	21	9	27
• Hospitalization (within or outside correctional system)	17	52	10	30	6	18
• Administrative segregation/separation[c]	0	0	2	6	2	6
• Unspecified segregation/separation	2	6	1	3	0	0
• Case-by-case determination	13	39	15	45	10	30

[a] This includes hypothetical policies in jurisdictions that as yet have no cases in a particular category.

[b] This category includes single-celling.

[c] This category includes housing inmates in medical units for administrative reasons. This policy is generally intended to protect affected inmates from other inmates and/or to facilitate their supervision.

tions still hospitalize or administratively segregate at least inmates with AIDS. City and county and Canadian jurisdictions are slightly more likely to use segregation: 18 percent of responding city and county jurisdictions and 25 percent of Canadian systems segregate all three AIDS-related inmate categories as opposed to only 10 percent of state and federal systems. Two-thirds of all systems responding in 1987 have basic policies involving case-by-case determination of housing.

Increasingly, correctional systems are basing housing decisions on both medical and security/behavioral considerations. This, in turn, is based on the multiple objectives of providing care consistent with medical need, protecting the inmate from harm at the hands of others, and preventing transmission of HIV within institutions. At the same time, however, many correctional systems are coming under significant pressure to segregate all asymptomatic seropositives and inmates with ARC. There has also been significant pressure to restrict work assignments of HIV-infected inmates.

The specific medical and correctional management considerations involved in each of the major housing options are examined below.

Major Housing Options

Maintaining Inmates in the General Population Without Special Programming

Decisions to keep inmates in the general population involve consideration of measures necessary and appropriate to protect affected inmates from other inmates and to minimize the risk of HIV infection being transmitted. CDC guidelines recommend no special housing arrangements for AIDS or ARC patients except under certain clearly defined medical circumstances. These circumstances primarily involve protection of the *patient* from other infection rather than protecting other people from the patient's infection. As shown in Figure 5.4, a number of systems maintain entire AIDS-related categories of inmates, particularly seropositives, in the general population without any special programming. For example, New York City and New York state estimate that their systems have significant numbers of seropositive inmates in the general population. However, largely

Figure 5.3

HOUSING POLICIES FOR INMATES WITH AIDS, ARC, AND ASYMPTOMATIC HIV INFECTION: CANADIAN SYSTEMS (n = 12)[a]

Policy	Jurisdictions Following this Policy for: AIDS n	%	ARC n	%	Asymptomatic HIV Infection n	%
• Maintain in general population	1	8%	1	8%	2	17%
• Maintain in general population with special programming[b]	0	0	1	8	0	0
• Hospitalization (within or outside correctional system)	5	42	4	33	3	25
• Administrative segregation/separation[c]	3	25	1	8	1	8
• Unspecified segregation/separation	0	0	0	0	0	0
• Case-by-case determination	6	50	7	58	7	58

---

[a] This includes hypothetical policies in jurisdictions that as yet have no cases in a particular category.

[b] This category includes single-celling.

[c] This category includes housing inmates in medical units for administrative reasons. This policy is generally intended to protect affected inmates from other inmates and/or to facilitate their supervision.

due to extensive educational programs on AIDS, this has not occasioned panic regarding transmission of infection.

A number of other correctional systems (including Illinois, Indiana, Louisiana, Maryland, Massachusetts, Virginia and Washington) maintain all asymptomatic seropositives and inmates with ARC in the general population without special restrictions. A few systems (such as Michigan and Oregon) presumptively house all three categories of HIV-infected inmates in the general population, unless an individual's medical needs, safety, or high-risk behavior dictate otherwise. It is more common, however, to segregate AIDS cases but presumptively house seropositives and inmates with ARC in general population, with provision for their segregation on a case-by-case basis if they display high-risk behavior or a need for protection or medical conditions that calls for separate housing. Florida, Iowa, and the Federal Bureau of Prisons follow this policy.

Maintaining Inmates in the General Population with Special Programming

In a number of systems, asymptomatically infected inmates and those with ARC are maintained in the general population, but with special programming designed to reduce the possibility that they will transmit HIV to others. In Texas and Nevada, for example, these inmates are housed together in double cells, while in Nebraska and New Hampshire, they are single-celled. Obviously, policy decisions in this area depend upon the degree of overcrowding in the facility. Some systems, such as California, house all general-population inmates in double cells while in New York state all celled inmates have their own cells. Dormitory housing with double-bunks is also prevalent in many systems with prison overcrowding problems, such as Florida, while in other systems, including New York, all dormitory housing is in single-bunk cubicles. A lack or shortage of single-cell housing in general population may lead a system to decide on segregating seropositives and/or inmates with ARC. Even if single-celling is available on a limited basis, placing all HIV-infected inmates in single cells would be tantamount

Figure 5.4

HOUSING POLICY COMBINATIONS[a]

	State/Federal Prison Systems				City/County Jail Systems			
	Original Survey: November 1985		Third Survey: October 1987		Original Survey: November 1985		Third Survey: October 1987	
Policy Combination	n	%	n	%	n	%	n	%
• Segregate AIDS Cases; ARC Cases and Seropositives Maintained in General Population	3	6%	6	12%	3	9%	3	9%
• Segregate AIDS and ARC Cases; Seropositives Maintained in General Population	10	20	2	4	3	9	2	6
• Segregate All Categories	8	16	5	10	13	41	6	18
• No Segregation of Any Categories	2	4	1	2	0	0	2	6
• No Policy	8	16	0	0	1	3	0	0
• Combinations Involving Case-by-Case Determination	16	31	36	71	10	30	19	58
• Other Policy Combinations	4	8	1	2	3	9	1	3
Total	51	101%[b]	51	101%[b]	33	101%[b]	33	100%

---

[a] For the purposes of this categorization, segregation means that the *basic* policy is to hospitalize (either with correctional system) or to segregate administratively the particular category of inmate, regardless of whether returned to the general population when their symptoms subside.

[b] Due to rounding.

to announcing their identities to staff and other inmates. Systems choosing this option must consider the impact of this notification on the infected inmates' safety in the general population.

In many correctional systems (45 percent of federal/state systems, 36 percent of city/county systems, and 25 percent of Canadian systems) the work assignments of inmates with ARC and/or those with asymptomatic HIV infection are restricted. For example, in Nebraska and Nevada, these inmates are excluded from food service assignments. In other correctional systems, HIV-infected inmates are excluded from medical, dental and laundry duties. Correctional systems generally acknowledge that restrictions on work assignments are not medically indicated: the likelihood of transmission in any of these assignments is extremely remote. Nevertheless, restrictions on these assignments have been instituted to forestall any potential alarm. Nevada and some other correctional systems also exclude infected inmates from work release programs in the community, in order to maintain public support for the programs.

Systems should carefully weigh medical and correctional considerations before instituting such restrictions. Unnecessarily extreme precautions may undermine educational programs designed to convince inmates and staff that the AIDS virus is only transmitted through sexual activity and blood-to-blood contact. Indeed, an inmate raised such a concern at an AIDS training session observed during this study. After the physician had finished her presentation on the means of transmission, including the point that there have been no cases of infection attributed to food, the inmate asked: "Then why are infected inmates not permitted to work in food service?" The physician was not able to provide a sound answer to the question, which may well have fostered suspicion among the attendees as to the real risk of HIV infection associated with food.

Segregation: Medical and Administrative

Every jurisdiction places inmates with confirmed diagnoses of AIDS in some hospital or infirmary setting when they are seriously ill. A variety of treatment settings are used for inmates with AIDS. Some states place all inmates with AIDS in hospitals in the community (New Jersey), while others maintain them in correctional medical facilities (California, Federal Bureau of Prisons) and still others use both community hospitals and correctional medical facilities (New York state). In several states, however, there have been difficulties finding community hospital placements for inmates with AIDS. At least two jurisdictions have centralized the treatment of all inmates with AIDS in a single correctional medical facility (California: Vacaville; and New York City: Rikers Island Hospital). All inmates with confirmed AIDS in these jurisdictions are permanently admitted to the centralized medical facility.

States which use hospital facilities for treatment will often admit AIDS cases when they are acutely ill but return them to a special unit in the correctional facility when they are in remission. This has proved to be a cost-effective approach.

Within medical facilities, some jurisdictions have policies involving medical isolation and quarantine of inmates with AIDS. Such policies run counter to CDC's guidelines for care of AIDS patients. These guidelines state that, in most instances, medical isolation is not necessary. Private rooms are indicated only when the patient is too ill to use good hygiene (e.g., suffers from profuse diarrhea or fecal incontinence) or displays altered behavior as a result of central nervous system infection.[7] Connecticut and other state systems have explicit policies against isolation of AIDS patients unless it is medically indicated.

Though hospital and infirmary settings are generally designed for medical treatment and evaluation, some jurisdictions also use these facilities to separate inmates with AIDS from the general correctional population, to protect them from retribution, and to prevent them from infecting others. Some jurisdictions (including Florida, Illinois, Indiana, Kentucky, and Maryland) permanently segregate confirmed AIDS cases in such settings immediately upon diagnosis. Still others (including Maine and Oklahoma) permanently place both AIDS and ARC cases in administrative segregation. Finally, a few correctional systems (including California, Texas, and Colorado) permanently segregate all three categories of HIV-infected inmates.

There is significant disagreement regarding segregation policies. Most correctional systems take the position that, while it may be necessary to segregate confirmed AIDS cases permanently, it is unnecessary to segregate seropositives or inmates with ARC except when dictated by specific medical, behavioral, or security considerations. According to the infectious and communicable diseases coordinator of the New York state correctional system, it is unfair to subject these inmates to the stigma of segregation in the absence of a cure for HIV infection. Indeed, as will be discussed below, New York has recently changed its policy on confirmed AIDS cases from permanent segregation to "mainstreaming" them (returning them to general population) when they are in remission.

Other correctional systems argue that there is good reason to segregate all HIV-infected inmates. In California, all of these inmates are housed in one wing at the Correctional Medical Facility at Vacaville. Correctional officials assert that this clustering facilitates delivery of the same correctional programs offered to all other inmates and makes it possible to provide all of these segregated inmates with medical and psycho-social services by highly experienced staff. Moreover, this arrangement makes it easier to protect infected inmates from other inmates who may wish to harm them. Officials state that, for this reason, the infected inmates themselves desire to be segregated. Further, segregation may prevent infected inmates from transmitting HIV to others. This latter motivation is closely tied to concerns regarding the system's potential liability for any infections that may occur in its facilities. It may be problematic, however, to cluster all HIV-infected inmates without respect to other classification considerations. It is probably preferable to place infected inmates in different housing units according to whether or not they are actively ill.

Development of separate housing units for infected individuals may have considerable impact on correctional costs. Single-celling, development of separate units, and medical isolation are all expensive, especially if these placements are used for asymptomatic seropositives and inmates with ARC. Moreover, it is costly and complicated to provide equal programming to inmates in such special units. Failure to provide equal programming may result in lawsuits. On the other hand, advocates of segregation argue that, by reducing HIV transmission, it will save the correctional system substantial costs associated with the medical care of inmates with AIDS.

Returning Inmates in Remission to the General Population

Once inmates are separated from the general population, it may be difficult to send them back, as this might cause concern among other inmates and staff. Still, there are cases of such policy changes being implemented without causing great difficulty. For example, in Michigan an inmate with AIDS was medically segregated but then returned to the general population without incident when his disease went into remission. Michigan officials emphasize the importance of a concerted and continuous education program and the cooperation of the correctional officers' union in achieving this success.

In New York state, a recent policy change encourages returning inmates with AIDS in remission to the general population. This policy has been implemented gradually, in order to minimize fear. One approach has been to mainstream these inmates at other facilities where they will not be generally known to have AIDS. Another strategy is to reintegrate each inmate into the same institution gradually over several months. For example, an inmate may first return to religious services while still living in the infirmary and then, some time later, return to vocational programs, and, finally, return to general population housing. At one New York maximum-security facility, the inmates in a vocational shop actually petitioned for the return to work of an inmate with AIDS in remission. The inmate was peacefully returned to work.[8]

Case-by-Case Determination

As noted earlier, survey results reveal a continuing trend away from blanket segregation policies, particularly for asymptomatic seropositives and inmates with ARC. The movement is toward case-by-case determination, based on a range of considerations, including the inmate's medical situation, safety, and likelihood of infecting others. Blanket segregation policies were more common early in the epidemic and generally represented a first reaction to the problem. With a period of time to consider all of the facets of HIV infection in the correctional setting, most systems have shifted to a case-by-case approach.

Some jurisdictions, including Kansas, Michigan, and South Carolina, make all housing and programming decisions case-by-case, on the basis of medical and security considerations. Michigan's policy, which is particularly well-conceived, is included in Appendix G. In summary, the policy states that "HIV-infected prisoners who do not require inpatient care will be eligible for general population housing at any institution which can meet their health care and security needs, and will also be eligible for any programming and work assignment which their health and behavior allows." As an alternative to inflexible segregation policies, Michigan has implemented an extensive program for identifying and monitoring high-risk behaviors and making timely housing and programming decisions for inmates exhibiting such behaviors.[9] This requires meetings between the institution head and medical director at least monthly to review the conduct of prisoners known to be infected and prisoners believed to be engaging in high-risk behavior. Oregon and Pennsylvania[10] also base housing decisions on a comprehensive assessment of each inmate's medical needs and behaviors.

According to the Oregon Correctional Division's health services director, the state's policy is that "since non-infected individuals can avoid the major risk of exposure to the AIDS virus by abstaining from [sexual activity and needle-sharing], it is not medically necessary to separate infected individuals to avoid spread of the disease." However, individual decisions have been made to segregate particular inmates for their own protection, to prevent panic among the inmates, or in response to certain medical conditions.[11]

Several systems, including the Federal Bureau of Prisons, Iowa, and Indiana specifically prescribe segregated or separated housing for seropositive inmates who give evidence of predatory or other high-risk behavior. The Federal Bureau of Prisons has developed an elaborate hearing, appeal, and review process for its decisions.[12]

Conversely, New York state, New York City, San Francisco, and Los Angeles, among other jurisdictions, take special care to identify prisoners who might be victimized and to offer them special housing for their *own* protection. Obviously, sexual assault is of heightened concern because of the possibility of HIV transmission in such events. Los Angeles, San Francisco, and New York City have separate jail units for homosexual men. In San Francisco, inmates requesting separate housing are also placed in this unit. In New York state, the correctional system's basic strategy for preventing rape is to identify and separately house prisoners who may be victimized because they are of small stature, are overtly homosexual, or display other behavioral characteristics which may put them at risk. This policy, in conjunction with aggressive programs to identify, carefully supervise, and, if necessary, segregate potential predators, may be able to minimize or even eliminate the possibility of HIV infection through forced sexual activity. However, this can only work in the context of case-by-case housing decisions.

Case-by-case determination recognizes that each case is unique. It allows the flexibility to shape particular responses to the medical and non-medical characteristics of particular cases. On the other hand, the subjective judgments which may be made under a case-by-case approach and the lack of uniform policies linked to clear AIDS-related categories of inmates may cause concern among staff, other inmates, or public officials. Intensive educational programs should be able to allay such concerns.

A policy based on case-by-case decisionmaking may also be more vulnerable to legal challenges on the basis of adequacy and equitability of treatment. However, such problems should be minimized by careful attention to the medical and non-medical characteristics of each case.

Precautionary and Preventive Measures

Correctional agencies have instituted a wide range of precautionary measures to control the spread of AIDS within institutions. Some of these measures, especially those based on CDC guidelines for the prevention of HIV transmission in health-care and other workplace settings, offer excellent protection while minimizing cost and inconvenience within the institution. (Examples of correctional policies in this area are included in Appendix G.) Others go well beyond the CDC guidelines and are probably unnecessary and inappropriate.

Universal Precautions

CDC has promulgated guidelines for health-care workers and others who may come into contact with HIV-infected persons on the job.[13] Many jurisdictions have made these CDC guidelines a part of their correctional policy regarding AIDS.

The CDC guidelines emphasize *universal precautions*: that is, "[s]ince medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, blood and body fluid precautions should be consistently used for *all* patients." This recommendation applies equally to correctional officers and inmates, as well as to all persons involved in law enforcement or other public safety work.

These precautions are similar to those recommended for preventing infection with Hepatitis-B. As noted in Chapter One, since HIV is less hardy and more difficult to transmit than the Hepatitis-B virus,[14] precautions designed to prevent transmission of Hepatitis-B should be more than sufficient to prevent transmission of HIV. Measures beyond those recommended for Hepatitis-B are considered unnecessary and inappropriate for addressing the HIV risk.

The complete CDC guidelines are included in Appendix E to this report, but the following summarizes the precautionary measures recommended, with some adaptation to the correctional setting:

- avoid needlesticks and other sharp instrument injuries;
- wear gloves when contact with blood or body fluids is likely;
- use disposable shoe coverings if gross blood contamination is encountered;
- establish a "self-help barrier" by keeping all cuts and open wounds covered with clean bandages;
- avoid smoking, eating, drinking, nail-biting, and all hand-to-mouth, hand-to-nose, and hand-to-eye actions while working in areas contaminated with blood or body fluids;
- wash hands thoroughly with soap and water after removing gloves and after any contact with blood or body fluids;
- clean up any spills of blood or body fluids thoroughly and promptly, using a 1:10 household bleach dilution;
- clean all possibly contaminated surfaces and areas with a 1:10 household bleach dilution;
- place all possibly contaminated clothing and other items in clearly identified, impervious plastic bags;
- avoid sharing toothbrushes, razors or other items that might transmit blood.

In addition to its guidelines for clinical staff, CDC has recently promulgated similar universal precautions for dental workers.[15] Several correctional systems have also implemented these precautions—not because of possible exposure to saliva, but because of the potential exposure to blood involved in scaling procedures and other routine dental work. Florida and other systems have recommended universal precautions for dental workers.

All correctional agencies should develop and enforce written policies and procedures regarding precautionary measures and protective equipment. Uniform, reasonable, and consistently applied policies help to eliminate confusion and avoid unnecessary incidents resulting from overreaction or misinformation. The Wisconsin correctional system has developed a comprehensive infection control policy and carries out regular assessments of compliance with that policy in all its institutions. Figure 5.5 shows that most correc-

Figure 5.5

WRITTEN PRECAUTIONARY POLICIES IN CORRECTIONAL SYSTEMS

	Federal/State Systems (n = 51)		City/County Systems (n = 33)		Canadian Systems (n = 12)	
Policy	n	%	n	%	n	%
Overall Precautionary Policy	44	86%	30	91%	9	75%
Gloves	44	86	26	79	9	75
Other Protective Clothing	31	61	18	55	6	50
CPR	38	75	23	70	7	58
Search Procedures	23	45	18	55	4	33
Cleanup of Spills	43	84	27	82	9	75
Needle Handling	39	76	27	82	8	67

tional support systems have adopted written precautionary policies in certain key areas, including gloves, CPR, clean-up of blood and body fluid spills, and needle handling. Search procedures—such as use of gloves, mirrors, and flashlights – should be incorporated into all systems' precautionary policies.

The California Department of Corrections has issued a useful set of precautionary policies for its staff. This covers protective apparel, cell and body searches, control of inmate disturbances, dealing with aggressive or violent inmates, clean-up of blood or body-fluid spills, and other relevant topics.[16] (This policy is included in Appendix G.) Correctional departments should issue protective latex or rubber gloves for staff to carry at all times. In many systems, officers have belt pouches in which to carry gloves. However, in several systems, gloves are not issued to individual officers but only made available at key locations. One institutional superintendent argued that individual issuance of gloves would only cause concern among staff. However, it appears that the arguments for issuance of gloves to individuals outweigh those raised in opposition.

Judgment in Implementation

Precautionary measures should always be commensurate with the risk involved. Obviously, correctional personnel cannot predict with certainty when they will encounter blood or body fluids in the course of their duties. In almost any situation, there may be the potential for such contact. However, it would be an overreaction to wear gloves at all times. This could also undermine the critical educational message that HIV infection is not transmitted by casual contact.

Instead, correctional staff should exercise their professional judgment as to when there is a reasonable likelihood of contact with blood or body fluids and exercise reasonable care in those situations, just as they do in addressing the other types of risks common in their work.

Response to Specific Situations

Fights and Assaults

When suddenly confronted with an altercation in which contact with blood or body fluids may occur, a correctional officer must quickly make a critical decision. "Should I intervene?", and, if so, "Should I stop to put on gloves before intervening?" Correctional staff in some systems seem to have adopted an informal policy of non-intervention for fear of infection. However, this does not constitute an appropriate discharge of the officer's responsibilities.

The California Department of Corrections' policy states that staff "must assess each incident as to the urgency of the situation" and take appropriate action. In a non-life threatening situation, officers are directed to put on gloves. In a life-threatening situation, the first responding staff member will determine the need for gloves. However, when blood is present and an inmate is combative or threatening to staff, gloves must always be worn.[17] It is also important to avoid striking individuals in the mouth, or indeed, to avoid any hand-to-mouth contact, because this is likely to result in bleeding. These recommendations should be useful, but professional skill and judgment are still required in facing such situations.

Human Bites

As discussed in Chapter One, the risk of infection through human bites is very low. However, the following simple precautions will minimize the risk of HIV and other infection as well as promote basic hygiene:

1. encourage "backbleeding" by applying pressure and "milking the wound", as with a snakebite;
2. wash the area thoroughly with soap and hot water; and
3. seek medical attention as soon as possible.

HIV antibody testing of the victim and perpetrator of the bite may be appropriate. However, there is always the possibility of a false negative result. Therefore, knowledge of antibody status of either or both of the individuals involved in the incident should not change the medical response to the victim's case: the same surveillance and care of the wound should be undertaken in all instances.

Body and Cell Searches

Although the risk of HIV infection from being cut or punctured by contaminated needles or other sharp instruments is very low, many correctional personnel are concerned about such incidents. Cuts, needlesticks, and puncture wounds may be sustained by officers while searching inmates or cells, or while handling sharp items in a variety of situations. There is particular concern regarding searches of areas where sharp objects may be hidden from view—such as spaces beneath bunks and the pockets of clothing. The following precautionary measures will help to minimize the risk of infection:

- whenever possible, ask inmates to empty their own pockets;
- whenever possible, use long-handled mirrors and flashlights to search hidden areas;
- if it is necessary to search manually, always wear protective gloves and feel very slowly and carefully; and
- use puncture-proof containers to store sharp instruments and clearly marked plastic bags to store other possibly contaminated items.

Latex gloves are currently the only type suitable for conducting searches. Although they can provide some protection against sharp instruments, latex gloves are not puncture-proof. Moreover, there is a direct tradeoff between level of protection and manipulability. In other words, the thicker the gloves, the more protection they afford but the less effective they are in locating objects. Agencies should select the thickness of glove which provides the best balance of protection and search efficiency.

Cardiopulmonary Resuscitation (CPR)

Correctional personnel are also concerned about infection with HIV through administration of CPR. Agencies should respond to these concerns by emphasizing the research showing the extreme unlikelihood of HIV transmission through saliva. At the same time, agencies should make protective masks or airways available to officers and provide training in their proper use. Devices with one-way valves to prevent the patient's saliva or vomitus from entering the caregiver's mouth are clearly preferable. California state law now requires training on CPR masks with one-way valves for all peace officers, including correctional officers.

Blood or Body Fluid Spills

All spills should be promptly cleaned up using a 1:10 solution of household bleach. "Clean-up" kits are now commercially available and "spill kits" are manufactured by the Corrections Industries Program in Wisconsin. The commercial clean-up kits include a granular absorbent which contains bleach. This is to be poured on the spill and allowed to absorb it, and then swept up and discarded in a special impervious bag. Next, an aerosol bleach is sprayed on the area, allowed to sit for ten minutes and wiped up with an absorbent towel. Finally, the staff member washes his or her hands with an antiseptic rinse. All equipment necessary for the complete clean-up operation is included in the kit. The California Department of Corrections has purchased these clean-up kits for many of its institutions.

Unnecessary Preventive Measures

Some correctional agencies have instituted protective measures which go far beyond those recommended by CDC. Many of these measures are designed to limit exposure under extremely unusual circumstances or to prevent exposure through casual contact. Precautionary measures addressing very rare or casual modes of contact, even if implemented in a good faith effort to reduce the fears of staff and inmates, may ultimately increase those fears by encouraging the view that the infection is transmitted by the sorts of unusual or casual contact they address. Such a conflict between educational messages and practical measures may not only increase fear within the institution, but also foster suspicion of the correctional system for, in effect, saying one thing about the transmission of HIV but doing something else. No special clothing are necessary for correctional staff except gloves and, in the case of gross body fluid contamination, masks and gowns.

CDC recommends no special handling of the laundry and linen of persons with HIV infection or AIDS and no separate toilet or shower facilities. Finally, because there is no evidence that HIV can be transmitted through food, CDC recommends no special provisions for food service and no special handling of utensils used in the preparation or service of meals for infected inmates.

Restrictions on Inmate Visitation Privileges

Some correctional systems restrict the visitation rights of HIV-infected inmates. California, New York, and Mississippi exclude all infected inmates from conjugal visits. This policy was recently upheld in a New York lawsuit.[18]

Availability of Condoms for Inmates

There has been a great deal of discussion regarding whether condoms should be made available to correctional inmates. Most systems have resisted this step (as they have resisted distribution of clean needles or bleach to sterilize needles) on the grounds that it would condone or even encourage prohibited and, in some jurisdictions, illegal activity. Moreover, many correctional officials also believe that condoms would be used to make weapons and to conceal drugs and other contraband.

Nevertheless, three correctional systems—Vermont, New York City, and Mississippi are now making condoms available to inmates. Vermont was the first correctional system to take this step. In announcing their decision, Vermont officials stated that the system was not thereby condoning homosexual activity among inmates, only acknowledging that it occurred and, given that fact, taking a logical step to prevent HIV infection. In Vermont, condoms are only available through medical staff after counseling on high-risk behaviors.

This is the same approach taken by the New York City Department of Corrections. After conducting a study which demonstrated a significant number of cases of rectal gonnorhea contracted by New York City jail inmates while incarcerated—which in turn demonstrated that homosexual activity was occurring—the city health department recommended that condoms be made available in all city jails. This policy was initially established for the gay unit on Riker's Island, but it will soon be extended to the entire system. As in Vermont, condoms are only available through medical staff. In New York City, there have been no reported problems with condoms being used as weapons or to conceal contraband. Finally, in Mississippi, condoms are sold in institutional canteens. This state's policy summarizes well the case for condom availability:

> Realizing that preventive programming will not eliminate irresponsible sexual behavior in the inmate population and acknowledging the recommendations of the Surgeon General of the United States of America that condoms will help prevent sexual transmission of HIV infection, condom usage should therefore be advocated by any credible and responsible education/prevention program. Consistent with these concerns condoms will be made available.[19]

Several other jurisdictions, including Washington, and the Canadian federal correctional system, make condoms available for conjugal visits but not for use in the institution. California does not furnish condoms for family visits, but permits spouses to bring their own. Finally, some correctional systems, including those in New York City and San Francisco, provide condoms to inmates on release. All New York City releasees receive a "discharge kit," which includes AIDS prevention brochures, a card with AIDS hotline telephone numbers, and two condoms.

Conclusion

This chapter has discussed four key areas of policy: medical management, counseling and psycho-social services, housing policy, and precautionary measures. Major findings and recommendations include the following:

- Quality medical care should be provided to all inmates infected with HIV. AIDS patients, in particular, need humane and supportive care and access to AZT and other therapeutic drugs as indicated.
- Emphasis should be placed on proactive identification and monitoring of inmates at high risk of HIV infection and AIDS. This should be done through comprehensive intake screening and regular follow-up.

- Comprehensive psycho-social services and pre-release planning are also essential for inmates with asymptomatic HIV infection, ARC and AIDS. This must include pre- and post-test counseling and guidance on responsible behavior to avoid the infection of others.
- Costs of care for inmates with AIDS are very high, but may be reduced by eliminating unnecessary hospitalizations. At the same time, such reductions may be counterbalanced by the high cost of AZT, which is becoming a major correctional cost concern.
- Most correctional systems still segregate or hospitalize inmates with AIDS, but there has been a noticeable trend away from blanket segregation of asymptomatic seropositives and inmates with ARC. Systems should consider case-by-case housing and programming decisions based on the inmate's medical situation, need for protection, and likelihood of engaging in behaviors that may place others at risk.
- Correctional systems should establish "universal precautions" for blood and body fluids. That is, unprotected contact with the blood or body fluids of *everyone* should be avoided.
- Reasonable and consistent precautionary procedures should be established to help staff safely deal with a variety of situations, including altercations, blood spills, searches, CPR, and biting incidents.
- Correctional systems should not adopt precautionary measures beyond those recommended by CDC for clinical staff.
- Several correctional systems currently make condoms available to inmates in institutions, emphasizing that this is not to condone prohibited behavior but only to recognize that it occurs and to provide for reasonable risk reduction. Other correctional systems may wish to assess this experience in reaching their own policy decisions.

Notes

1. Illinois Department of Corrections-Medical Services, *AIDS Manual*, Section VI: Screening, Identification and Surveillance of High Risk Individuals.
2. Beverly Abplanalp-Gaede and George L. La Fountain, "Educational and Therapeutic Intervention and Advocacy for Prisoners with HIV Infection," Presentation at 11th National Conference on Correctional Health Care, Chicago, November 7, 1987.
3. Don Wardrope (Psychiatric Nurse Consultant, Augusta Correctional and Medical Institution, Grovetown, Georgia), "An AIDS/ARC Support Group in a Correctional Institutional Setting: General and Specific Considerations," Paper presented at the 10th National Conference on Correctional Health Care, Washington, D.C., October 31, 1986.
4. CDC, "Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS," *MMWR* August 14, 1987; 36:509-515.
5. J. Sisk, "The Costs of AIDS: A Review of the Estimates," *Health Affairs*, Summer 1987; 6:5-21.
6. S.D. Williams, "Corrections New Balancing Act: AIDS," *Corrections Compendium*, August 1987; 11:1, 6-9.
7. *MMWR* 1982; 31:577-580.
8. Abplanalp-Gaede and La Fountain, "Educational and Therapeutic Intervention and Advocacy for Prisoners with HIV Infection."
9. "Protocol for the Prevention and Management of HIV Infection in the Michigan Department of Corrections," (October 1986), pp. 9-11.
10. Commonwealth of Pennsylvania, Department of Corrections, "Correctional Policy for the Management of HIV Infection," March 3, 1987.
11. Catherine M. Knox, Letter to Oregon State Representative Carl Hosticka, October 28, 1985.
12. *Federal Register*, October 8, 1987; 52: 37730-37732.
13. CDC, "Recommendations for Prevention of HIV Transmissions in Health-Care Settings," *MMWR* August 21, 1987; 36:3S-18S; "Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace," *MMWR*, November 15, 1985; 34: 681-695.
14. G. H. Friedland, and R.S. Klein, "Transmission of HIV," *New England Journal of Medicine*, October 29, 1987; 317:1127.
15. *MMWR*, August 21, 1987; 36:3S-18S.
16. California Department of Corrections, Administrative Manual, Section 6111, "Precautions Against Exposure to the AIDS Virus When Handling Inmates – General Guidelines for Department Staff," October 5, 1987.
17. California Department of Corrections, Administrative Manual, Section 6111.
18. *Doe v. Coughlin*, 509 NYS 2d 209 (NY App. 1986), reported in Buraff Publications, *AIDS Policy and Law*, December 2, 1987; 2:5.
19. Mississippi Department of Corrections, "Policy and Procedure: HIV Infection," August 1, 1987.

Chapter 6: Confidentiality, Legal and Labor Relations Issues

This chapter discusses one of the most sensitive issues regarding AIDS in correctional facilities and everywhere else – who receives information on the medical status of individuals. It also discusses a range of legal issues involved in a rapidly growing caselaw on AIDS in correctional facilities, key labor relations issues, and recent relevant legislative developments.

Notification and Confidentiality

Decisions regarding who should receive inmates' HIV antibody test results and who should be notified regarding inmates' diagnoses of AIDS or ARC are difficult and complex. Although both inmates and correctional staff have asserted legal claims of a right to know test results (based on perceived health risks associated with not knowing), seropositive individuals have conversely asserted claims of a right to privacy. While too few cases have been decided to offer a firm answer, it is fair to say that indiscriminate circulation of inmates' HIV antibody test results to staff offers few benefits – and may entail a risk of liability.

Decisions regarding confidentiality and disclosure are often governed by legal and policy standards, such as requirements for written authorization to release test results or other medical records. Where law or policy allow any discretion, decisions regarding disclosure versus confidentiality invariably raise the question of which should take precedence: the inmate's right to have medical information kept confidential or the correctional system's perceived legal and moral responsibility to protect its staff and other inmates, as well as the public, from HIV infection. There are valid claims on both sides of the argument. On the one hand, it is often argued that correctional management need to know test results to make informed classification and programming decisions. In addition, line correctional officers argue that they have a right to know when they are dealing with inmates who may be infectious or who have a serious communicable disease. Notification to public health departments and inmates' former and/or subsequent correctional systems may also be considered important to facilitate treatment, prevention measures, and contact tracing. Such disclosures may also be designed to reduce or eliminate the correctional system's legal liability should a released or transferred inmate transmit HIV infection to others.

On the other hand, the most compelling reason for maintaining confidentiality is that persons known to have AIDS, ARC, or asymptomatic HIV infection may suffer ostracism, threats and possibly violent intimidation while in prison; and discrimination in employment, housing, and insurance coverage after discharge from prison. Moreover, if "universal" blood and body fluid precautions are being followed, knowledge of antibody status may be not only unnecessary but also dangerous. If correctional officers think they know who all the infected inmates are, they may be lulled into a false sense of security with regard to the inmates they think are uninfected. In short, a double standard of precaution may be encouraged.

Because of their rapid population turnover rates, jails face even more difficult policy decisions and logistical problems regarding disclosure and confidentiality of medical information.

Overview of NIJ Survey Results

Figure 6.1 summarizes the survey results regarding disclosure of HIV antibody test results. This shows that many systems limit notification to the inmate and medical staff, but a significant number of systems also inform correctional management and/or public health departments. (In some jurisdictions notification to the public health departments is required by law.) However, very few correctional systems (18 percent of state/federal systems in the United States, 3 percent of city/county systems, and 25 percent of Canadian systems) notify line correctional officers of antibody test results.

Below, we discuss the range of options regarding disclosure of all types of AIDS-related medical information. The discussion references relevant legal and policy requirements.

Range of Options Regarding Who Receives Information

Very Restrictive Provisions

In many states, including California, Florida, Illinois, Massachusetts, Oregon, and Wisconsin, there are very restrictive laws regarding disclosure of HIV antibody test results. Under California law, only the subject may receive the results of the test unless he or she gives written authorization for others to receive them. Written consent is required for each separate disclosure. Moreover, the law specifies that no one can be compelled to identify the subject or divulge the results of

Figure 6.1

POLICIES REGARDING DISCLOSURE OF INMATES' HIV ANTIBODY TEST RESULTS[a]

Who Receives Results?	State/Federal Prison Systems (n = 51)		City/County Jail Systems (n = 33)		Canadian Systems (n = 12)	
	n	%	n	%	n	%
• Inmate	50	98%	29	88%	8	67%
• Attending Physician	51	100	23	70	8	67
• Other Medical Staff	40	78	19	58	7	58
• Correctional Department Central Office	27	53	3	9	5	42
• Correctional Institution Management	30	59	2	6	7	58
• Correctional Officers	9	18	1	3	3	25
• Public Health Department	27	53	13	39	6	50

---

[a] Includes immediate disclosures and disclosures on transfer/discharge.

any test in a legal action without the written consent of the subject. Test results are not subject to disclosure under California's employee "right-to-know" law. Finally, in California, test results may not be used to reach any decision regarding employment or insurability.

Under Wisconsin's law, the only legal recipients of test results are the subject, the subject's health-care provider, laboratory personnel and other staff of health-care facilities, and the state epidemiologist. Any disclosure to others requires a court order. In states such as California and Wisconsin, correctional staff other than health care personnel may not be legally authorized to obtain test results.

To maximize confidentiality protection, it may be advisable to have HIV antibody testing of inmates done at one of the CDC-funded alternative test sites which are located nationwide. All testing at these sites is anonymous; no names are recorded and results can only be obtained by using a code number known to the subject alone. However, there are serious practical problems with this approach. Moreover, results of testing done in response to clinical indications would generally have to be available to medical staff. The following paragraphs describe some other options for addressing confidentiality issues in the correctional setting.

Role of Medical Staff

Medical staff — in particular, the inmate's attending physician — have an obvious need to know HIV antibody test results. The information may be important for diagnostic and treatment purposes. Correctional medical staff also have a critical role to play in protecting the confidentiality of this information, and, indeed, of all medical information regarding individual patients. The only exceptions to the maintenance of confidentiality for information regarding HIV infection should arise from serious safety or security considerations.

A number of correctional systems have adopted policies which strictly limit the disclosure of information on HIV infection. Illinois's policy states that "divulging or sharing of information with non-medical staff may result in disciplinary action. Patient confidentiality is an ethical obligation and must be strictly adhered to by all staff."[1]

Medical staff in correctional systems have developed several strategies for maintaining confidentiality. New York state keeps no lists of infected inmates, makes no entries regarding HIV infection in medical records, and in no way flags medical records of infected inmates. In New Mexico, the word AIDS does not appear in an inmate's medical record unless and until final diagnosis. Alaska's policy is to request HIV antibody tests by identifying number unrelated to the inmate's normal identification number. No names appear on the blood samples, and the linkage between inmate names and identifying numbers is kept locked in the secure area where controlled drugs are stored.

If correctional systems do keep lists of infected inmates – and, as will be discussed below, some do – it is absolutely critical that these lists be kept locked in secure locations. It should be impossible for inmates working in the medical facility, correctional officers, or any other unauthorized persons to obtain access to such a list or to individual medical records.

Notification of Correctional Authorities and Correctional Officers

Many correctional authorities and correctional officers argue that they need to know the results of HIV antibody tests in order to make classification and programming decisions and to protect themselves against infection in their day-to-day interactions with inmates. The arguments for and against mass screening of inmates for antibodies to HIV have already been discussed (see Chapter Four), as well as the key arguments for and against widespread disclosure to correctional staff. As noted above, very few correctional systems have policies for the routine notification of correctional officers.

Selected disclosures will probably be required, however, for certain carefully defined purposes. Two key decisions are really involved:

1. Who receives information? and
2. What information do they receive?

Possible answers to both of these questions run from the very specific to the very vague, and from the very restrictive to the very broad. Correctional systems should define as precisely as possible both the information and the recipients. Vagueness inevitably causes problems. Nevertheless, many correctional systems have overbroad policies regarding disclosure of information on HIV infection.

Several state correctional systems provide information or lists of infected inmates to institution superintendents and leave it to their discretion to decide who else should be notified. The assumption is that this policy results in disclosure to correctional officers who work directly with the inmate. Some jurisdictions simply have adopted the policy that information will be shared with those who have a "need to know". This begs the question, because there is significant disagreement about precisely who has such a need.

Other correctional systems have attempted to develop more specific policies. In Vermont, the institutional superintendent is informed of all positive HIV antibody tests, but that information is to be shared with other staff members only if one of the following criteria is met:

1. There is reason to believe the offender is prone to aggressive or violent behavior toward staff, or
2. There are specific medical considerations which might place the staff at unnecessary risk.[2]

Wisconsin's policy is similar, but it specifically covers disclosures in the event of a possible transmission incident. In such cases, there appears to be a strong case for disclosure, particularly if the incident involved an aggressive act by the infected inmate. Indeed, as discussed in Chapter Four, airtight laws against forced testing and disclosure of results may soon be modified to allow for testing and disclosure following potential transmission incidents.

In Michigan, the institution head is informed when an infected inmate is identified, but the specific diagnosis is not disclosed. Rather, Michigan focuses on "behaviors which need to be eliminated". Accordingly, the institution head and medical director meet on at least a monthly basis to review the conduct of all infected inmates and all inmates displaying high-risk behaviors.[3]

Some correctional systems, including Iowa's, have made specific provision for disclosure to officers who are transporting an infected inmate. However, in many jurisdictions, the specific diagnosis is not revealed. In New York, for example, transportation officers are simply advised to "take normal precautions." Many correctional systems make provision for vague disclosures regarding "infectious diseases" or "bloodborne diseases". These may in fact preserve confidentiality, since such warnings may be issued with regard to inmates with diseases other than AIDS, but they may also be codes which technically preserve confidentiality while issuing specific notifications.

When inmates are transferred, correctional systems generally send their full medical file to the new institution. This may include any diagnoses of AIDS or

ARC, and, in some cases, information on HIV seropositivity as well.

Notification of Other Criminal Justice Agencies

An important issue to resolve is how far the chain of notification should extend within the criminal justice system. For example, should parole authorities be notified of a potential parolee's medical status? It may be questionable from a legal standpoint for this information to be available to parole decisionmakers. However, there is also the question of whether parole officers or community corrections staff should be notified of an inmate's medical status once parole has been approved. Again, the test should be whether such officials have a clear need to know in order to make programming decisions and placements and/or to protect themselves or others from infection. A number of correctional systems, including Missouri, Maine, and Iowa, routinely notify parole and community corrections authorities of releasees' HIV antibody status.

Another question likely to arise is the following: if an intake test reveals HIV seropositivity or an inmate develops AIDS or ARC, should the system notify the city or county jail from which the inmate came to determine if the inmate had sexual contact or shared needles with any inmates there? Other institutions and organizations outside the correctional system do not generally provide such notifications.

Notification to Public Health Departments

Fifty-three percent of state/federal systems, 39 percent of responding city/county systems and 50 percent of Canadian systems routinely notify public health agencies when an inmate is determined to be HIV-seropositive. Under Colorado law, state and local public health departments must be notified of all positive HIV antibody test results. This law was passed so that public health authorities could be alerted to the presence of potentially infectious individuals and so that such individuals could be counseled regarding the meaning of their test and measures necessary to prevent transmission of the virus. However, under the Colorado law, public health departments must maintain the test results in strictest confidence. The information is not available to insurers or employers without permission of the subject. Several other states, including Nevada and Louisiana, now have laws requiring notification of public health departments.

Notification of Spouses/Sexual Partners

Some correctional administrators believe that they may have a moral responsibility to notify the spouse or sexual partner of inmates with AIDS, ARC, or asymptomatic HIV infection prior to authorizing any conjugal visits or furloughs and prior to the inmate's discharge. The question that arises here again is whether correctional systems should bear more responsibility than do institutions in the community at large, which generally require no such notification. In other words, should correctional administrators rely on counseling and education on AIDS, as is the general procedure in the outside world, or do the particular characteristics of correctional inmates necessitate further interventions?

A number of concerns will affect these decisions, not the least of which is the correctional system's desire to avoid legal liability should an inmate infect someone else while on furlough or conjugal visit. Some states attempt to avoid the problem by excluding HIV-infected inmates from such programs. Others, such as Connecticut, make conjugal visits contingent on the inmate's notification of his or her spouse or sexual partner.

However, even with such policies, the larger issue of what to do at parole or release must be answered. To minimize the risk of liability, each agency should adopt a written policy specifically requiring the physician (or other health-care provider) who may know of an individual's positive HIV antibody status to counsel such individuals regarding their obligations to inform all sexual partners of their medical condition. According to recent CDC guidelines, in the event an infected individual refuses to notify his or her sexual partners, the health-care professional should consider making confidential notification. The policy of the Michigan correctional department is in line with this CDC recommendation.[4] California recently passed a law specifically permitting physicians to notify the spouses of HIV-infected persons.

Contact Tracing

When certain communicable diseases are diagnosed, attempts are sometimes made to identify the source from whom an individual contracted the disease and anyone whom an individual might have exposed to the disease prior to his or her diagnosis. Such "contact tracing" is sometimes attempted in AIDS cases. For example, the Alaska Department of Corrections interviews all inmates found to be HIV-infected regarding possible partners in sexual or needlesharing activities and undertakes notification of those contacts.[5]

While potentially useful in certain limited situations, such contact tracing may also produce serious problems: the number of individuals involved in the inquiry expands almost geometrically, and these individuals' privacy is invaded and their lives are disrupted out of all proportion to the real risk that they transmitted or acquired the AIDS virus. Indeed, some physicians and epidemiologists believe that contact tracing is not likely to work in AIDS cases because of the difficulty in pinpointing the specific incident resulting in infection and because there is no treatment which might provide an incentive for persons to admit contact. Mandatory contact tracing programs may also undermine efforts to develop voluntary cooperation with AIDS prevention efforts.[6]

Danger of Disclosure to Other Inmates

As discussed in Chapter Four, it is extremely difficult to maintain the confidentiality of HIV antibody test results in a correctional environment, particularly when a policy of mandatory mass screening is in place. Despite the system's best efforts to preserve confidentiality, it is almost inevitable that at least some other inmates will learn the identity of those infected with HIV. Active AIDS or ARC will, of course, be more noticeable than asymptomatic infection.

Some inmates will themselves disclose their medical status. Otherwise, many events may serve to "tip off" other inmates. The inmate "rumor mill" is especially attuned to such information and it is likely to spread very rapidly. If, for example, inmates are moved to other cells or other parts of the institution without other explanations, this could serve to label them as infected. Similarly, otherwise inexplicable exclusion of an inmate in prison for a relatively minor offense from work release or other programs would create suspicion.

This all serves to underline the importance of extreme and consistent care in guarding the confidentiality of this extremely sensitive information. Disclosure may place an inmate in a very difficult and dangerous situation in the institution. There should be severe sanctions for unauthorized breaches of confidentiality.

Legal and Labor Relations Issues

In late 1985, when the first edition of this report was prepared, most legal issues regarding AIDS in correctional facilities remained potential or theoretical; few actual cases had been filed. Since then, however, numerous cases have been filed by inmates, and a few have reached disposition. Most cases have been filed in United States District Courts, although some have been filed in state and county courts as well. To date, few AIDS-related cases have been instituted by correctional staff. This reflects the fact that there have been no cases of seroconversion, AIDS or ARC among correctional staff attributable to contact with inmates. By 1987, almost 40 percent of federal/state systems had been involved in AIDS-related litigation. Fewer city/county systems (9 percent) had been involved in litigation.

This section summarizes caselaw and legal and labor relations issues under the following headings.

- Issues Raised by Inmates
  - General standards for correctional medical care
  - Challenges to segregation and conditions of confinement
  - Quality of care in AIDS cases
  - Challenges to HIV antibody testing
  - Duration of incarceration
- Issues Raised by Inmates and Staff: Protection from HIV Infection
  - Mandatory screening and segregation
  - Confidentiality of medical information
  - Correctional systems' liability for HIV infections
  - Testing in response to potential transmission incidents
- Issues Raised by Staff
  - Labor relations issues
  - Obligation to perform duties
  - Employees with HIV infection and AIDS

Issues Raised by Inmates

General Standards for Correctional Medical Care[7]

There is substantial caselaw on correctional medical care in general which is important for administrators to consider in developing policies regarding AIDS. Indeed, AIDS should not necessarily be considered a unique correctional health issue; legal standards and correctional policies regarding communicable diseases in general may be applicable to AIDS and may have already been tested in court. The major legal standards and causes of action on correctional health care are discussed below.

Suits on the quality of correctional medical care may

110

be brought on the basis of federal Constitutional standards, state law, or common law. Plaintiffs may seek judgments under 42 USC 1983, the provision which essentially gives citizens the legal right to sue the government.

There are three basic federal Constitutional standards and principles relevant to correctional medical care. First, under the Eighth Amendment, inmates are entitled to a safe, decent and humane environment, although the Fifth Circuit has held that this does not mean they are legally entitled to rehabilitative or recreational programs while in prison.[8] Second, in *Estelle v. Gamble*,[9] "[d]eliberate indifference to serious medical need" was held to violate the Eighth Amendment protection against "cruel and unusual punishment." Finally, because of segregation issues, the Federal constitutional guarantee of "equal protection of the laws" is relevant to correctional medical care cases, and particularly to cases involving inmates with AIDS.

Medical care in correctional institutions is usually governed by the same state laws (e.g., Medical Practice and Nursing Practice Acts) that apply to care in the community at large. However, inmates are not necessarily entitled to all aspects of medical care available in the community at large—for example, the right to choose one's own physician and the right to a second medical opinion. Finally, in some states, correctional medical care may be subject to suits for common law torts such as negligence. Medical malpractice suits are also a possibility.

Challenges to Segregation and Conditions of Confinement

A number of cases have been brought by inmates with AIDS, ARC or asymptomatic HIV infection alleging that the conditions of their confinement violate equal protection standards and/or constitute cruel and unusual punishment. In the first such case, *Cordero v. Coughlin*,[10] a group of segregated inmates with AIDS sued the New York State Department of Correctional Services alleging cruel and unusual punishment and deliberate indifference to their serious medical needs. They claimed that their segregation unconstitutionally fostered depression and deterioration in their medical condition. The inmates also argued that they had been deprived of equal protection of the laws by being medically segregated. While the plaintiffs conceded that there is no absolute right to rehabilitation programs, exercise or visitation, their suit argued that inmates with AIDS must have the same access to these as do other inmates in the system. However, the plaintiffs alleged that, by reason of their segregation, they were unconstitutionally deprived of such programs and benefits. Moreover, they claimed that they were forced to live under conditions worse than those in the disciplinary unit, without any finding of a disciplinary violation—simply because they had AIDS.

The court found for the Department of Correctional Services, holding that inmates have no constitutional right to freedom from segregation instituted to advance a reasonable correctional objective. Segregation is proper if it is necessary for the protection of inmates with AIDS and other inmates in the institution. The court also held that there was no Eighth Amendment violation because the plaintiffs had not shown that they were denied adequate food, clothing or shelter. Finally, the equal protection claims were denied because the constitutional guarantee applies only to "similarly situated" groups or individuals, and the inmates with AIDS and the other inmates in the institution were not, in the view of the court, similarly situated.

An Oklahoma case, *Powell v. Department of Corrections*, raised some of the same issues as *Cordero v. Coughlin*. In this case, an HIV seropositive but asymptomatic inmate filed suit alleging denial of equal protection in that he was isolated from the general population, constantly supervised, and denied access to worship and exercise. The major difference between this case and *Cordero* concerns the very different medical conditions of the plaintiffs. However, the court reached the same conclusion as in *Cordero*. It declared that the segregation policy furthered legitimate correctional objectives, namely prevention of the spread of disease and protection of the seropositive inmate from other inmates. Further, the court stated that inmates have no constitutional right to be in general population and that the inmate had not been denied equal protection since he had not been treated differently from other seropositive inmates—in fact, no other seropositive inmates had been identified in the Oklahoma prison system.[11]

In *Farmer v. Levine*, a seropositive inmate in the Baltimore County Detention Center was isolated in a disciplinary unit and denied access to rehabilitation programs, the law library, and religious services. (The last two restrictions were removed after the suit was instituted.) The plaintiff also complained that guards routinely wore masks when entering his cell, left his meals at the opposite end of the cell rather than handing them to him directly, and subjected him to other forms of abuse. Farmer alleged that all of this constituted punishment without due process (i.e. that he was placed in the disciplinary unit without a hearing on any specific conduct), as well as denial of equal protection, right to privacy, and freedom of expression and association. The state, citing *Cordero*, responded that the isolation was not punitive but rather was in furtherance of a legitimate institutional objective—prevention of the spread of disease. A magistrate recommended that the county's segregation policy be upheld, but the case became moot when the plaintiff was transferred to federal prison.[12]

In an Alabama case, an inmate alleged that his segregation and disqualification from work release programs due to his seropositivity were unconstitutional. As in the other cases, the state responded that these restrictions were justifiable on the basis of institutional security and health. The court, citing *Cordero* and *Powell*, ruled in favor of the Alabama correctional system.[13]

Finally, in a recent Maryland case, the court upheld the *medical* segregation of an inmate with AIDS. Since this case involved segregation ordered by medical staff rather than by correctional administrators, the court stated that it need not rule on the validity of administratively segregating inmates infected with HIV.[14]

In Colorado, by contrast, the Department of Corrections has eased its segregation policy for seropositive inmates. In motions filed under *Marioneaux v. Colorado State Penitentiary*, a broad correctional conditions case pending since the 1970s, seropositive inmates complained of being placed in a maximum security segregation unit next to death row, in violation of an objective classification system previously agreed to by the correctional department. The state pleaded "special circumstances," but plaintiffs countered that the classification scheme contained no provision for special circumstances. Ultimately, the correctional department decided to move those seropositive inmates who ordinarily would have been classified as medium security or lower to a medium security unit.[15]

A pending Massachusetts case refines the equal protection arguments advanced in *Cordero* and *Powell*. This case, *Johnson v. Fair*, contests the permanent hospitalization of an AIDS patient, even when his symptoms are in remission. The plaintiff bases his equal protection argument on the current policy of the correctional system which allows inmates with ARC, but not inmates with AIDS (who are similarly situated in that both groups are infected with HIV and capable of infecting others), to return to the general prison population. This argument did not prevail in the inmate's request for a preliminary injunction, but will be further considered in the main case. Finally, in Missouri, a group of segregated HIV-seropositive inmates filed suit seeking access to an outside exercise yard for one hour per day. A Federal magistrate recommended denial of their request for a preliminary injunction on the ground that the plaintiffs had no constitutional right to "touch the ground" and that their access to sundecks in the fourth-floor segregation unit met constitutional standards. Moreover, the magistrate agreed with the correctional system that the seropositive inmates might be at risk for physical harm if they were permitted access to the exercise yard.[16]

Several recent Nevada and New York cases involve complaints from HIV-infected inmates regarding their rights to work programs and visitation. In *Williams v. Sumner*, a seropositive Nevada inmate sought reversal of his exclusion from a community work program. The court denied the claim on the ground that prisoners have no independent constitutional right to employment.[17]

In *Doe v. Coughlin* an inmate with AIDS complained of denial of conjugal visits. This case was decided in favor of the Department of Correctional Services, and the decision was recently upheld by the state's Court of Appeals. As with the segregation cases, the basis of the decision was that an inmate's "rights are necessarily limited by the realities of confinement and by the legitimate goals and policies of the correctional system". A dissenting opinion contended that the state's action constituted an "invidious discrimination" against the plaintiff's right to "personal decision-making [within] their marital privacy right". Following initiation of another New York suit, a correctional system policy was changed to permit HIV-infected inmates to receive visits from their children.[18]

In sum, while several cases remain pending, courts have upheld the discretion of correctional officials to segregate HIV-infected inmates and deny them access to certain programs and privileges where the policy is deemed to be based on legitimate medical, safety, and institutional security considerations.

Quality of Care in AIDS Cases

Typically, these are cases brought by inmates with AIDS alleging inadequate medical care or "deliberate indifference" to serious medical need. In *Thagard v. County of Cook*,[19] an inmate with ARC filed suit for damages alleging inadequate medical care in that he was repeatedly denied an "AIDS examination" which he had requested. The inmate had developed some symptoms of ARC but, as of the time of the suit, had not developed AIDS. The court found for the correctional department on the ground that the inmate had shown no actual injury to have resulted from the failure to provide the examination. Notably, the court stated that while good medical practice probably would have been to provide the requested examination, it could not enforce good medical practice. An Alabama inmate's suit alleging that he was not provided evaluation and treatment for syphillis and AIDS as he had requested was dismissed by a federal judge. The court again held that it could not and would not substitute its opinion for that of the physician responsible for the inmate's case. In a pending Florida case, an inmate alleges that he should have been diagnosed with ARC sooner and that, as a result of the late diagnosis, his medical condition suffered.[20]

Permanent hospitalization, which may seem at first glance a convenient way to segregate inmates with AIDS from others, may in some cases be medically inappropriate. Because AIDS and ARC involve extreme susceptibility to infections (and because hospitals are filled with infectious disease patients), hospitals may create special health risks for persons with AIDS and ARC. In a case currently pending in Massachusetts, an inmate with AIDS, whose symptoms are in remission, is contesting his permanent assignment to a hospital, in part based on the increased risk to his health.[21] A key question in deciding this case—and a key issue for administrators who hope to avoid similar suits—will be whether or not the hospital assignment is medically indicated.

A class action in Nevada challenging a broad range of correctional conditions includes a complaint of inadequate attention to the medical needs of the state's seropositive inmates.[22] In a recently filed Idaho case, an HIV-seropositive inmate alleges that he was provided inadequate medical care,[23] and several HIV-seropositive inmates housed in a prison hospital in Mississippi charged that the correctional department failed to provide them adequate protection. One of these inmates was poisoned. This matter was resolved without a lawsuit.[24] Finally, a wrongful death suit may soon be filed on behalf of a former Los Angeles County inmate who died of AIDS while in custody.[25]

These cases raise a number of important issues, including timely diagnosis and undertreatment. These may be particular risks if the correctional medical staff is unprepared to meet the often intense medical needs of AIDS and ARC patients, or if it is hampered by exaggerated fears of AIDS. In this regard, staff education is absolutely necessary. The legal risks—not to speak of the human costs—of inadequate care may be very high.

Challenges to HIV Antibody Testing

As yet, there have been no inmate suits challenging mandatory mass screening for antibodies to HIV. However, there have been several challenges to other applications of antibody testing. In Connecticut an inmate sought to block blind epidemiological studies of the prevalence of HIV in the correctional population,[26] but the case was dropped by the plaintiff. An Oklahoma inmate alleges that he was tested against his will, and this case is still pending.[27]

The question of mandatory testing following potential transmission incidents will be discussed later in this chapter.

Duration of Incarceration

This is still primarily a policy issue, but it surely has legal implications. Some correctional administrators consider early release for inmates with AIDS, while some judges and others advocate extended confinement of infected individuals.

As the number of persons with AIDS within jails and prisons has increased—and as increasingly ill persons faced the prospect of spending their last days in prison—executive clemency and early release have been considered. In New York state, a discretionary early release policy for AIDS patients, based on humanitarian considerations, led to the parole of fifty offenders by March 1987. In other states, including Massachusetts, similar policies are being considered.[28]

There are several areas of concern surrounding early release of persons with AIDS. First, agencies certainly have a moral—and probably, as well, a legal—obligation to ensure that such releasees are not simply "dumped" onto the street. As discussed in Chapter Five, there must be careful and comprehensive planning and followup to ensure that released individuals receive all medical benefits and other support services to which they are entitled.

Second, early release programs may raise concern among the public about the future safety of spouses, sexual partners, and others with whom the releasee may come into contact. Under New York policies, parole is discretionary, but is not specifically dependent upon parolees' agreeing to notify, or permit notification of sexual partners or others potentially at risk. Since state law prohibits disclosure without permission, family members may be unaware of risk factors. The parole board encourages counseling of releasees to notify their sexual partners and favors parole only of extremely ill inmates or those with "strong predictions of good behavior."

As yet, there have been no claims against parole boards or correctional systems for negligent release leading to infection of a member of the public, but the possibility of such claims is important to consider. To protect against possible liability, early parole should be granted only for humanitarian reasons, should involve careful planning and followup on aftercare, and should be contingent upon thorough counseling of the parolee regarding his or her responsibilities to avoid infecting others. In addition, as was discussed earlier, officials should take steps to notify the sexual partners of infected persons who refuse to carry out such notification themselves.

Several correctional systems and judges believe that inmates with AIDS should be kept in the medical care of the system as long as possible (e.g., no parole, no transfer to minimum security institutions, no pre-release placement in halfway houses or community-based programs), to provide better care, to minimize the risk of HIV transmission, and to reduce the system's potential legal liability.

This policy option raises serious legal issues. Mentally ill persons may be legally committed or otherwise segregated for extended periods if they are deemed to pose a threat to society or to themselves. However, the situation of the inmate with AIDS is different: the risk that he or she will transmit the infection largely involves consensual acts rather than forcible victimizations. A possible exception may be the violent sexual offender who is infected with HIV; the question logically arises whether such individuals' medical status should influence parole or release decisions. In general, such decisions should probably be based on a combination of medical and non-medical factors (e.g., the inmate's medical status and an assessment of the likelihood that he or she would engage in violent or other non-consensual acts by which the infection might be transmitted). However, decisions that extend the period of incarceration can probably not be supported on the basis of medical factors.

Issues Raised by Both Inmates and Staff: Protection from HIV Infection

There are a number of AIDS-related legal issues that can, and have, been raised by both inmate and correctional staff. These are discussed below.

Mandatory Screening and Segregation

Numerous cases have now been filed by inmates alleging that correctional systems have not provided them adequate protection from HIV infection while in prison. Most seek mandatory HIV antibody screening and segregation of seropositives. The first case of this type was *La Rocca v. Dalsheim*, in which a group of healthy New York state inmates sought injunctive relief from the policies of the Downstate Correctional Facility which allegedly provided inadequate protection against the spread of HIV infection. However, the court held that the segregation policies and precautions followed at the institution were adequate to protect the inmates. Significantly, the court also declared that "[i]n view of the scientific uncertainty concerning . . . AIDS, and the reluctance of the court to intervene in the day-to-day management of a prison, no procedural regimen regarding the protection of the rights of AIDS-free inmates shall be judicially mandated."[29]

However, this case arose before the HIV antibody tests became available, and now many suits have been filed seeking antibody screening and other policies for the systematic identification and separation of infected inmates. Thus far, all disposed cases have been decided in favor of the correctional systems' policies not to institute mass screening. However, many of these cases demonstrate that misinformation about AIDS still influences attitudes and actions in correctional institutions.

A North Carolina case seeking mass screening of inmates, as well as steps to halt homosexual activity in prison and an end to sharing of kitchen utensils, toilet facilities, clothing and bed linen with infected inmates, was decided in favor of the correctional department. A number of Florida cases demanding an end to homosexuals working in prison food service, and protection against homosexuals spreading HIV infection through assaultive and consensual sexual acts have been dismissed.[30] A North Carolina case seeking mass screening was recently dismissed, as was a case from Florida. A similar case was dismissed by the U.S. District Court for Southern Indiana on the ground that state legislatures and correctional officials, not federal courts, can best decide how inmates should be protected from AIDS.[31] In Oregon, "mainstreaming" of HIV seropositive inmates was upheld and in Arizona, a case seeking removal of an inmate with AIDS from a correctional institution was dismissed.[32]

Finally, a Pennsylvania case was similarly decided, but raised some potentially troubling legal precedents. In this case, an inmate alleged that his constitutional rights had been violated by the correctional system's failure to segregate HIV-infected inmates. The court dismissed the particular claim as frivolous, but took note of *Lareau v. Manson*, in which a correctional system's failure to screen inmates for a communicable disease constituted a violation of due process and "deliberate indifference to serious medical needs".[33] The applicability of *Lareau* depends upon whether AIDS is categorized as a "communicable disease".

Inmate cases seeking mandatory mass screening, segregation of seropositives and/or other similar measures are pending in Nevada, Oregon, Massachusetts, Idaho, Kentucky, Louisiana, Oklahoma, and Arkansas.[34] The Arkansas case also calls for discharge of any staff who develop AIDS, removal of any seropositive correctional staff from contact with other staff and inmates, and systematic reporting of all AIDS cases to the correctional department and the state health department. A pending Florida case alleges that the correctional department was negligent in failing to prevent an inmate from adulterating coffee with the blood of an AIDS patient.[35]

Two pending New Jersey cases allege failure to follow established administrative and medical screening policies and demand systematic identification and segregation of high-risk inmates and those with symptoms of HIV infection, as well as more and better inmate training on AIDS. The plaintiffs also call for expanded HIV antibody testing on a voluntary basis.[36] A Pennsylvania inmate seeks release from prison or elevation of the institution's conditions to a constitutional level. He alleges wanton neglect by being placed in population with inmates who have ARC or AIDS, thus endangering his life.[37] Finally an Arizona suit seeks damages for "severe emotional distress" to an inmate as a result of his being housed in the same unit with ARC inmates.[38]

Confidentiality of Medical Information

As discussed earlier, most jurisdictions have strong laws and/or policies mandating confidentiality of medical information regarding HIV infection and AIDS. However, several cases have been filed by inmates alleging improper disclosure of such information, while correctional staff in at least two states have sought to obtain lists of all infected inmates.

In a recently-dismissed New Jersey case, inmates alleged that under current policies AIDS-related medical records might be seen by correctional officers. They also asked to be tested for HIV antibodies but to be freed from any disciplinary action for engaging in needlesharing activities that might have led to their infection.[39]

Several cases regarding AIDS-related information have been brought by inmates against the Federal Bureau of Prisons. In a recently dismissed case, a private attorney sued under the Freedom of Information Act for information on the number of AIDS cases, correctional management policies for inmates with AIDS, and training programs on AIDS.[40] In two other pending cases, inmates who had incidentally appeared in an AIDS training film allege that they have suffered damages because other inmates now believe they have AIDS.[41] Two Florida cases allege improper disclosure of antibody test results by the correctional department, and claim mistreatment as a result of that disclosure.[42]

On the other hand, correctional staff in Delaware and Nevada have sought lists of all IV-infected inmates in their respective systems. In Delaware, officers filed a union grievance claiming violation of a contract provision that they would be notified of the names of all inmates "suspected of having any communicable disease". The dispute arose after some twenty inmates, claiming to have had homosexual relations with another inmate who had died of AIDS, were voluntarily tested with a guarantee of confidentiality. An arbitrator determined that the correctional system must abide by the terms of the contract and disclose the names of the seropositives. The correctional system then filed suit challenging the arbitrator's decision, but the court allowed the decision to stand.[43]

In Nevada, where all inmates are screened for antibodies to HIV, correctional officers have made several attempts to gain access to the names of seropositive inmates. The state's attorney general issued an opinion that disclosure must be limited to those who "have a legitimate medical need to know in connection with the prevention and control of AIDS". This would not include all correctional officers. The officers' union countered that, because of the frequency of potential transmission incidents, all officers did have a legitimate need to know. The union intends to seek an OSHA ruling and new state legislation that mandate disclosure of the names of HIV-infected inmates to all correctional officers.[44]

Correctional Systems' Liability for HIV Infections

One of the most serious legal concerns of correctional systems is that they will be held liable should an inmate or staff member become infected with HIV while incarcerated or on the job. In upholding the medical segregation of an inmate with AIDS, a federal district court judge felt constrained to comment on the advisability of *administrative* segregation as well. He noted that "prison officials might face a §1983 suit for failing to isolate a known AIDS patient or carrier, if the carrier infects another inmate who could show that such failure to isolate constituted grossly negligent or reckless conduct on the part of such officials".[45]

A few cases have now been filed by inmates seeking damages for allegedly contracting HIV infection while in a correctional facility. A possible basis of such suits is failure to provide protection from sexual assault. Indeed, a recently-filed Florida case alleges infection through a gang rape in an institution.[46]

Inmate plaintiffs in suits alleging HIV infection in correctional institutions face two serious problems: 1) the difficulty of linking transmission to a particular incident, which is very difficult from a medical standpoint in almost all AIDS cases except those associated with blood transfusions; and 2) the problem of establishing that the correctional system was "grossly negligent or reckless" in permitting the incident to occur. Correctional systems have been required by courts to adhere to a standard of reasonable care in protecting inmates. Breaches of this standard may constitute cruel and unusual punishment.[47] In several cases, correctional systems and their officials have been held liable for damages resulting from homosexual rapes and other inmate-on-inmate assaults on the ground that inadequate supervision had been provided to prevent such incidents.[48]

However, correctional systems have not been held responsible for insuring the *absolute* safety of persons in their custody. In several cases, for example, courts have held that a correctional system could be liable for damages resulting from inmate-on-inmate assault only if its officials knew—or should have known—in advance of the risk to the particular inmate.[49] Moreover, in one case, the court held that there is no liability in mere negligence. In other words, the negligence must be of a gross or outrageous sort.[50]

In the case of transmission by consensual acts, the correctional system would appear to be on even stronger ground, particularly if it could establish an "assumption of risk" defense by proving that the inmate had been given education and training on the known means by which the infection is transmitted.[51]

To avoid any potential liability and to discharge its responsibility to provide a safe environment for inmates, correctional systems should attempt to prevent high-risk behavior among inmates, protect all inmates from victimization—especially those who are young, small, physically weak, or overtly homosexual—and avoid any practices which could lead to unprotected blood exposure. Clark County, Nevada, has been served with discovery requests preparatory to a possible lawsuit by a former inmate of the county jail who alleges that he was exposed to the AIDS virus through a jail policy requiring that inmates share razors.[52] This lawsuit will undoubtedly face serious proof problems because of the difficulty, noted above, of linking infection to a specific incident, particularly an incident of a type never implicated in transmission of the virus. However, this is an example of how an ill-advised policy such as requiring inmates to share razors can lead to legal complications.

Although no cases of this kind have yet been filed, correctional systems may also be concerned about legal liability should an employee be infected on the job. Departments are not legally required to insure the absolute safety of their employees, but only to adhere to a reasonable standard of care. Just as an agency would only be held liable for a gunshot wound or other injury incurred in the line of duty if established safety procedures had been violated or the department had been otherwise negligent, so in the case of HIV infection, such negligence would also need to be shown. (Of course, worker's compensation might well apply to either case, but would not entail the serious consequences of a finding of departmental liability.) The most obvious form of negligence would be failure to provide adequate training on precautionary measures against HIV infection. This would be a particular problem if the officer's infection could be shown to have resulted, even in part, from a failure to follow precautions.

Thus, it is important not only that training be given and safety procedures be followed, but that both training in and compliance with those procedures be documented. This documentation could be important evidence in future lawsuits.

Testing in Response to Potential Transmission Incidents

There continues to be controversy over whether a correctional system or individual staff member may compel an inmate to be tested for antibodies to HIV (and be told the results of this test) following a potential transmission incident. (Although the issue has not yet been raised, presumably this discussion also applies to the reverse situation—in which an inmate would seek the compulsory testing of an officer.) Here the issues of forced testing and disclosure of results are inextricable. It would hardly be worth having someone tested if the results were not to be disclosed to the interested parties. As discussed earlier, forced testing and/or disclosure are currently prohibited by law in many jurisdictions. However, at least some of these laws are likely to be modified in the near future to permit forced testing of persons involved in aggressive or reckless acts. In the meantime, many judges apparently believe that they have the right to issue court orders for such testing and disclosure. Indeed, since July 1987, two court orders have been issued in Houston requiring testing of inmates charged with sex crimes. Florida has a procedure for obtaining search warrants to compel "examination" of persons with sexually transmitted diseases, explicitly including AIDS.[53] Georgia correctional policy on testing in response to potential transmission incidents includes application for court orders should an inmate refuse testing. (The full policy is in Appendix G.)

On the other hand, at least two cases of this sort have also been decided against correctional officers or law enforcement officers. In a Massachusetts case, a trial judge ruled that an inmate who had allegedly scratched and spit on a guard could not be involuntarily tested to learn if he was infected with HIV.[54] The ruling was based on a state law prohibiting involuntary HIV antibody testing and disclosure of test results, and took note of the strong medical evidence against transmission of HIV through saliva. Similarly, a California court invalidated a search warrant authorizing HIV antibody testing of a defendant who was charged with biting a police officer while resisting arrest. The court based its decision on the state law prohibiting disclosure of test results without the informed consent of the subject.[55]

Issues Raised by Staff

Labor Relations Issues

Both through their unions and otherwise, correctional staff have raised concerns about the possibility of being infected with HIV on the job. Indeed, more than 30 percent of federal/state systems and almost 20 percent of city/county systems report concerted actions by employees regarding AIDS issues. As a result of their concerns, correctional employees, particularly those working in special AIDS units, have demanded "hazardous duty" pay and/or reduced working hours.

Obligation to Perform Duties

Despite the low risk of HIV infection associated with correctional duties, a number of agencies have faced potential work disruptions as staff members have refused to conduct searches, to transport prisoners, or to handle evidence out of fear of AIDS. About 20 percent of state/federal correctional systems and 15 percent of city/county systems have experienced such refusals by correctional officers. Since correctional staff have long assumed a wide variety of much greater risks – such as assaults, gunshot wounds, and so on – it is clear that administrators must offer leadership in placing the AIDS issue in its proper perspective. In general, agencies have taken the position that fear of AIDS does not excuse employees from performing their duties. The San Francisco Sheriff's Department sought a legal opinion from the city attorney's office as to whether deputies were required to render CPR to jail inmates known or suspected of being infected with HIV. The opinion was clear: deputies have an affirmative duty to provide CPR whenever necessary; failure to perform this duty could make the city liable for any resulting injury and subject the employee to disciplinary action.[56] Of course, jurisdictions should provide one-way CPR masks and training on their use, as is done in San Francisco.

Pregnant females represent the only category of employees who may be excused from duties due to AIDS-related concerns. In California, no pregnant women may be assigned to duty involving close supervision or care of persons with AIDS. This is because of the woman's risk of being exposed to cytomegalovirus (CMV), which is commonly excreted by persons with AIDS and which may cause birth defects. In addition, there is the general concern that a pregnant woman who contracted HIV infection from an inmate through a job-related exposure to blood or body fluids might perinatally transmit the infection to her child.

While appropriate training can do much to allay concern, departments may still face work refusals due to the highly emotional nature of AIDS-related fears. In most cases, departments have responded to unwarranted work refusals with swift and severe disciplinary action. In Kansas, a correctional officer was fired for refusing to work unless he was told which inmates were HIV seropositive, while two Vermont officers were disciplined for refusing to strip search a seropositive inmate and a Wayne County (Detroit) correctional officer was disciplined for refusing to work in close proximity to seropositive inmates. To minimize their susceptibility to legal challenge, disciplinary guidelines should be clearly specified in writing, should be explicitly based on accurate information about risk factors, and should be consistent with standard agency practice.

Moreover, clear and accurate training on AIDS must be provided. A Minnesota case illustrates the problems that can result from inadequate training. In this case, a corrections officer who was fired for refusing to search inmates was reinstated by an arbitrator, who noted that staff members had been given misleading information regarding AIDS; specifically, a memorandum including the advice that "no one really knows the way AIDS is transmitted, so be careful . . ."[57] The message for correctional administrators is clear: all training materials on AIDS must be precise and accurate, and all employees must be advised that, given proper training, they will be subject to disciplinary action if they refuse to perform their duties out of a fear of AIDS.

Employees with HIV Infection and AIDS

There have already been non-job-related cases of AIDS among staff members of correctional agencies. This raises the whole range of AIDS-related legal issues now being faced by many types of employers. Primary among these are the rights of persons with HIV infection and AIDS under the federal Vocational Rehabilitation Act and state handicap statutes and the effect of AIDS on relationships among employees in the workplace. Correctional administrators should address the second issue just as they address staff members' resistance to working with HIV-infected inmates; that is, fear of AIDS is no excuse for failure to perform duties.

The first issue is more complex. As yet, there have been no AIDS-related employee cases in correctional systems brought under federal rehabilitation laws or other handicap laws. The only legal matter which has arisen thus far regarding a correctional officer with AIDS involved an officer in the Federal Bureau of Prisons. After he informed his supervisor of the AIDS diagnosis, the officer was transferred to another position outside the institution. The officer filed an equal employment opportunity complaint seeking a return to his original position. However, a settlement was reached under which the individual's employment with the Federal Bureau of Prisons was terminated, but the FBOP agreed to continue paying for his health insurance.[58]

Correctional administrators should be familiar with the Vocational Rehabilitation Act of 1973,[59] which prohibits federal contractors and agencies receiving federal financial assistance from discriminating against handicapped persons in any employment context. The Supreme Court held, in *School Board of Nassau County, Fla. v. Arline*, that an infectious disease (tuberculosis) was covered by the Act. This holding was recently applied in the case of a California teacher with AIDS.[60]

In the *Arline* case, the court held that an employer may not arbitrarily fire, demote or segregate an employee who does not (as an HIV-infected officer would not) pose an immediate health risk to others while on the job. In addition, the employee must be reasonably accommodated, through reassignment if necessary, if he or she is unable to perform certain job duties due to illness. This decision seems to prohibit all adverse job actions against AIDS-infected employees based on their medical condition except those arising from physical inability to perform assigned duties.

Confidentiality and privacy concerns are just as important in developing policies for employees as for offenders. It is unlikely, for example, that policies mandating HIV antibody testing as a condition of employment in correctional systems will be upheld. Because of the extremely long incubation period and the uncertainty as to whether an infected person will ever become ill, antibody test results do not have a legitimate bearing on whether an applicant can do the job—the only valid criterion in making hiring decisions. Moreover, the possibility that an infected person would transmit the virus to someone else in the course of his or her duties is so remote as to remove it from legitimate consideration in employment decisions. On these grounds, the policy of a Maryland police department to screen all potential recruits for antibodies to HIV was halted by the county executive.[61]

Legislative Developments

During 1987, many legislative proposals regarding AIDS in correctional facilities were introduced. By far the most common legislative proposal was mandatory HIV antibody screening and segregation of all seropositives. More than thirty state legislatures considered such bills during 1987 and, although several came close to being adopted, none actually became law. A mandatory screening law was passed in Illinois, but vetoed by the governor. Several more limited laws regarding HIV antibody testing in correctional facilities were passed. A new Delaware law authorizes correctional health care personnel to order inmates to be tested for diagnostic purposes. A Nevada law requires testing of all prison releasees. Finally, a newly-passed Oregon law requires testing of persons convicted of sex crimes and drug-related offenses.[62] A number of correctional administrators believe that mandatory mass screening legislation will probably pass in some states in 1988.

Another area of legislative activity which is of great interest to corrections personnel is modification of existing laws and/or enactment of new laws to permit mandatory testing and disclosure of test results for individuals involved in violent, aggressive, or reckless acts which might transmit HIV to others. A package of laws was passed in Iowa in 1987 which would permit forced testing of inmates and disclosure of results in such situations, authorize correctional staff to be informed of the presence of any inmates who have contagious diseases, and permit segregation of HIV-seropositive inmates.[63]

Conclusion

This chapter has discussed the difficult issues surrounding confidentiality and disclosure of AIDS-related medical information in the correctional setting, as well as the key legal and legislative developments regarding AIDS in corrections. Among the findings are the following:

- Realistically, it is difficult to maintain the confidentiality of sensitive AIDS-related information in prisons and jails; however, because of the potentially serious consequences of unauthorized disclosure, it is essential that correctional authorities make the strongest possible efforts to preserve confidentiality. In many jurisdictions, confidentiality of AIDS-related information is specifically required by law.
- No disclosures should be made except where clearly required by medical, safety, or institutional security considerations.
- Policies should be adopted and enforced which specify clearly who is permitted to receive information, what information is to be disclosed, and under what circumstances. Vague policies permitting disclosure to those with a "need to know" are insufficient.
- In conformance with recent CDC guidelines, correctional medical staff should strongly counsel persons infected with HIV to inform their sex partners; if an individual refuses to notify his or her partners, then correctional medical staff should carry out the notification in a confidential manner.
- Since 1985, there has been a great increase in litigation related to AIDS in correctional facilities. This has focused on the following areas, among others:
  - challenges to segregation and conditions of confinement;
  - quality of medical care;
  - attempts to mandate mass screening of inmates for antibodies to HIV and segregation of seropositives;
  - confidentiality and disclosure of medical information.
- Most disposed cases on these issues have been decided in favor of correctional systems, on the grounds that their policies were in furtherance of legitimate medical, correctional management, or institutional security objectives. However, many cases remain pending.
- The legality of mandatory testing in response to potential transmission incidents remains unclear; it is clearly prohibited in many jurisdictions under current law, but many judges believe that they can issue court orders to require such testing in certain instances.
- Many correctional systems are worried about their potential liability for HIV infections which occur among inmates while incarcerated and among staff while on the job. There are serious difficulties in linking infection with a particular episode; however, correctional systems can probably eliminate any potential liability, and maximize safety in their institutions, by taking all reasonable steps to prevent inmates from being victimized and providing all inmates and staff with clear and complete training on how to avoid becoming infected with HIV.
- The most important AIDS-related labor relations issue is whether correctional employees should or may be excused from their duties out of fear of AIDS. Correctional and other law enforcement agencies have been clear on this issue: such refusals are unjustified and will result in disciplinary action.
- As yet, there have been no AIDS-related employment cases brought by correctional staff under federal rehabilitation laws. However, correctional agencies should keep abreast of the caselaw which strongly suggests that action against employees with AIDS or asymptomatic HIV infection on the basis of their medical condition is impermissible, unless directly tied to their ability to perform the job.
- There has been a great deal of legislative activity regarding AIDS in corrections during the last year. Most legislative proposals have called for mandatory HIV antibody screening of inmates and segregation of seropositives. While several more limited testing bills have passed, none of the mandatory mass screening proposals has become law.

Notes

1. Illinois Department of Corrections – Medical Services, "AIDS Manual," Section II-A.

2. Vermont Department of Corrections, Health Care Policy – Addendum (481.A), AIDS, Revised July 1987.

3. "Protocol for the Prevention and Management of HIV Infection in the Michigan Department of Corrections," p. 10.

4. CDC, *Morbidity and Mortality Weekly Report* (MMWR), "Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS," 1987, August 14. 36:509-515; "Protocol for the Prevention and Management of HIV Infection in the Michigan Department of Corrections," p. 9.

5. Alaska Department of Corrections, Policies and Procedures, Index #807.18, "Detection and Control of AIDS," August 17, 1987, p. 7.

6. See L. Gostin, and W.J. Curran, "The Limits of Compulsion in Controlling AIDS," in *AIDS: Public Health and Civil Liberties* (Hastings Center Report, Special Supplement, December 1986), p. 23-26.

7. This subsection is based largely on the presentation of Clair Cripe, Esq. of the Federal Bureau of Prisons to the NIC Meeting of Correctional Commissioners on AIDS, Atlanta, Georgia, November 6, 1985.

8. See, e.g., *Rhodes v. Chapman* 452 U.S. 337 (1981). On the lack of legal entitlement to rehabilitation and recreational programming, see *Newman v. Alabama* 559 F 2d 283 (5th Circuit, 1977. Cert. denied in part, *Alabama v. Pugh* 98 Sup. Ct. 3057 [1978]). See also *Hutto v. Finney* 437 U.S. 678 (1978).

9. 429 U.S. 97 (1976).

10. 607 F Supp 9 (S.D.N.Y., 1984).

11. U.S.D.C., N.D. Oklahoma, Nos. 85-C-820-C and 85-C-816-B, dismissed February 20, 1986. A similar Oklahoma case, *Morse v. Meachum* (U.S.D.C., W.D. Oklahoma, No. CIV-86-1309-T) was decided in favor of the correctional department in late December 1986.

12. *Farmer v. Levine* (U.S.D.C. – Maryland, 1985), No. HM-85-4284, 19. Magistrates Report dated May 28, 1986.

13. *Marsh v. Alabama Department of Corrections* (U.S.D.C. – N.D. Alabama) No. CV-86-HM-5592-NE. Decided April 20, 1987.

14. *Judd v. Packard*, unreported opinion, U.S.D.C. – Maryland, Civil Action No. S 87-1514, September 24, 1987.

15. *Marioneaux v. Colorado State Penitentiary*, 465 F Supp. 1245 (1979); interview with David Miller, Colorado ACLU.

16. *Johnson v. Fair*, (U.S.D.C. – D. Massachusetts, 1987). Civil Action No. 87-0217 Mc; *Macke v. Cowles* (U.S.D.C. – W.D. Missouri) Consolidated Cases No. 86-4447-CV-C-5, Magistrate's Report, October 1, 1987.

17. *Williams v. Sumner* 648 F. Supp. 510 (C.D. Nevada, 1986).

18. *Doe v. Coughlin* 509 NYS 2d 209 (NY App. 1986). Buraff Publications, *AIDS Policy and Law*, December 2, 1987; 2:5.

19. Unreported opinion: No. 85C 4429 (N.D. Ill., May 20, 1985).

20. *Hall v. Correctional Medical Systems, Inc.* (U.S.D.C. – M.D. Alabama) Civil Action No. 85-D-1261-N. Decided January 1987. *Lofton v. Dugger* (U.S.D.C. – S.D. Florida) No. 87-8465, filed June 1987.

21. *Johnson v. Fair*, (U.S.D.C. – D. Massachusetts, 1987), Civil Action No. 87-0217 Mc.

22. *Burns v. State of Nevada* (U.S.D.C., D. Nevada, No. CV-S-86-366-HDM); Interview with Attorney Robert Kossack.

23. *Cartwright v. State* (4th District Magistrate's Division), No. HC-2805.

24. NIJ Survey response.

25. Questionnaire response, Los Angeles County Sheriff's Department.

26. *Durham v. Commissioner of Corrections* (Hartford District Court) Civil No. H-87-623.

27. *Dunn v. White* (U.S.D.C. – N.D. Oklahoma) No. 87-C-753-C.

28. Ronald Sullivan, "New York State Paroles 50 Men Sick With AIDS," *New York Times*, March 7, 1987, p. 1.

29. *La Rocca v. Dalsheim* 120 Misc 2d 697 (NY 1983).

30. *Wiedmon v. Rogers* (U.S.D.C., E.D., North Carolina, No. C-85-116-G); *Maberry v. Martin* (U.S.D.C., E.D., North Carolina, No. 86-341-CRT); *Potter v. Wainwright* (U.S.D.C., Middle Dist. Florida, No. 85-1616-CIV-T15). *Stalling v. Cave* (2d Circuit, De Leon County); *McCallum v. Staggers* (5th Circuit, Lake County, No. 85-1338-CAOI); *Bailey v. Wainwright* (8th Circuit, Baker County); *Lloyd v. Wainwright* (2d Circuit, De Leon County, No. 86-3144).

31. *Jarrett v. Faulkner*, U.S.D.C. (S.D. Indiana), No. IP85-1569-C.

32. *Herring v. Keeney* (U.S.D.C., Oregon), filed September 17, 1985; decided July 1987. *Piatt v. Ricketts* (U.S.D.C. Arizona No. CIV-85-538-PHX).

33. *Foy v. Owens* (U.S.D.C., E.D. – Pennsylvania, 1986), Civil Action No. 85-6909; *Lareau v. Manson* 651 F. 2d 96 (2d Cir. 1981); *Bell v. Wolfish* 441 U.S. 520 (1979); *Estelle v. Gamble* 429 U.S. 97 (1976).

34. *Tooze v. Sumner* (U.S.D.C. – D. Nevada) No. CV-N-87-425-ECR. *Sheppard v. Keeney* (U.S.D.C. Oregon, filed October 7, 1985); *Malport v. Keeney* (U.S.D.C. Oregon, filed October 11, 1985); *Lane v. Dukakis*, Norfolk Sup. Ct. (Massachusetts) Civil Action No. 87-1129; *Hays v. State of Idaho* (4th District, Magistrates Division), No. HC-2799; *Gilbert v. State of Idaho* (4th District, Magistrates Division), No. HC-2800, 2825; *Brown v. Scroggy* (U.S.D.C. – W.D. Kentucky) No. C86-0306P (J); *Vincent v. State of Louisiana* (19th JDC) Nos. 307, 418; *Mattison v. Meachum* (U.S.D.C. – E.D., Oklahoma) No. 87-280-C; *Knight v. Henderson* (U.S.D.C. – D. Arkansas, No. PB-C-86-16).

35. *Elliot v. Department of Corrections and Prison Health Services*, (8th Circuit, Bradford County, FL No. 87-149-CA).

36. *Telepo v. Fauver* (U.S.D.C. D. New Jersey, Civil Action No. 85-1742 (HAA); *Hook v. Fauver* (U.S.D.C. D. New Jersey, Civil Action No. 85-5962 (HAA)).

37. *Fergley v. Faulconer* (U.S.D.C. – Middle Dist., Pennsylvania, No. 87-0909).

38. *Yates v. Lewis* (U.S.D.C. Arizona No. CIV-86-1538-PHX).

39. *Sheridan v. Fauver* (U.S.D.C. D. New Jersey), dismissed, November 1987.

40. *Lewisburg Prison Project v. Federal Bureau of Prisons* (U.S.D.C. – Middle Dist. Pennsylvania No. 86-1339).

41. *Torres v. James* (U.S.D.C., S.D.N.Y. No. 86-3112); *Wills v. Carlson* (U.S.D.C., S.D.N.Y. No. 86-6414).

42. *Niosy v. Bowles* (17th Circuit, Broward County, No. 87-10523-CM); *Adderly v. Department of Corrections* (U.S.D.C. – S.D. Florida) No. 87-1195, filed September 1987.

43. *State Department of Correction v. Public Employees Council 82* (Del Ch. 1987), Civil Action No. 8462.

44. *AIDS Policy and Law*, December 16, 1987; 2:5; *Carson City Nevada Appeal*, November 12, 1987, p. A-1O.

45. *Judd v. Packard*, (unreported opinion, U.S.D.C. D.–Maryland), Civil Action No. S 87-1514, September 24, 1987. Cites *Withers v. Levine* 615 F. 2d 158 (4th Cir.), cert. denied, 449 U.S. 849 (1980).

46. *T.C. Smith v. Department of Corrections* (U.S.D.C.–S.D. Florida), No. 87-6412, filed August 1987.

47. See, e.g., *Doe v. Lally* 457 F. Supp. 1339 (U.S.D.C. D.–Maryland, 1979; *Campbell v. Bergeron* 486 F. Supp. 1246 (U.S.D.C.–Middle Dist. Louisiana, 1980), aff'd. 654 F. 2d 719 (5th Cir. 1981); *Streeter v. Hopper* 618 F. 2d 1178 (5th Cir. 1980); *Rhodes v. Chapman* 101 S. Ct. 2392 (1981).

48. See, e.g., *Redmond v. Baxley* 475 F. Supp. 1111 (U.S.D.C. E. Dist. Mich. 1979); *Garrett v. United States* 501 F. Supp. 337 (U.S.D.C., N. Dist. Georgia 1980); *Saunders v. Chatham County* 728 F. 2d 1367 (11th Cir. 1982); *Kemp v. Waldron* 479 N.Y.S. 2d 440 (Sup. Ct. 1984); *Thomas v. Booker* 762 F. 2d 654 (8th Cir. 1985).

49. See, e.g., *Mosby v. Mabry* 699 F. 2d 213 (8th Cir. 1982); *O'Quinn v. Manuel* 767 F. 2d 174 (5th Cir. 1985).

50. *Daniels v. Williams* 474 U.S. 327 (1986).

51. This may be the situation in *L.M. Smith v. Department of Corrections* (U.S.D.C.–S.D. Florida), No. 87-8625, filed August 1987.

52. Interview with Attorney Robert Kossack, Las Vegas, Nevada.

53. §796.08 Florida Statutes (Supplement 1986). See Aylesworth, G. and Knabe, R., "Warrant for Examination for Sexually Transmitted Diseases," *Florida Police Chief*, December 1987; 13:63.

54. *Dean v. Bowie*, Suffolk Sup. Ct. (Massachusetts), Civil Action #87-4745.

55. *Barlow v. Superior Court* 236 Cal. Rptr. 134 (Cal. App. 4th Dist. 1987).

56. "Deputy Sheriff's Duty to Administer CPR," City Attorney George Agnost to Sheriff Michael Hennessey, July 1, 1985.

57. *AFSCME and State of Minnesota Department of Corrections*, 85 LA 1185 (Gallager, 1985); Government Employee Regulations Reporter 187 (December 1985).

58. *Swinney v. Meese* (U.S.D.C., N.D. California).

59. 29 U.S.C. Section 1791 et.seq.

60. 170 S. Ct. 1123 (1987); *Chalk v. United States District Court, Central District of California*, CA 9, No. 87-6418.

61. "AIDS Tests on Police Recruits Halted," *Baltimore Evening Sun*, September 30, 1987, p. D1.

62. Lewis, H.E., "AIDS: State Legislative Activity," *Journal of the American Medical Association*, November 6, 1987; 257: 2410-2414.

63. Lewis, "AIDS: State Legislative Activity."

APPENDICES

APPENDIX A

Resource List

- *Sources for Current General Information on AIDS*
- *Sources of Additional Information Related to AIDS in Corrections*
- *Audio-Visual Materials*

RESOURCE LIST

1. Sources of Current General Information on AIDS

- AIDS Program
  Center for Infectious Diseases
  Centers for Disease Control
  Atlanta, GA
  (404) 639-2891 general information
  (404) 639-3352

  Contact: David Collie
  Senior Public Health Advisor

  CDC produces a weekly publication, *Morbidity and Mortality Weekly Report*, which contains frequent updates on medical and epidemiological research on AIDS. A bound collection of articles entitled *Reports on AIDS Published in the Morbidity and Mortality Weekly Report* includes all *MMWR* articles relating to AIDS since 1981 and is available from CDC.

- U.S. Public Health Service
  Room 725-H
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  (202) 245-6867
  (800) 342-AIDS National AIDS Hotline provides recorded message for general public 8:30 a.m. to 5:30 p.m.

- American Red Cross
  17th and D Streets, N.W.
  Washington, D.C. 20006
  (202) 728-6554

- NYC Department of Health
  125 Worth Street, Room 222
  New York, NY 10070

  (212) 566-8290
  (212) 566-8292 } general information

  (718) 485-8111 NYC Department of Health AIDS hotline 9 a.m.-9 p.m. Monday-Sunday

- NY State Department of Health
  AIDS Institute
  10 East 40th Street, 11th Floor
  New York, NY 10016
  (212) 340-3388

- San Francisco AIDS Foundation
  333 Valencia Street, 4th Floor
  San Francisco, CA 94103
  (415) 864-4376

- State and local public health departments may be contacted for more information.

2. **Sources of Additional Information Related to AIDS in Corrections**

- National Institute of Justice AIDS Clearinghouse
  National Criminal Justice Reference Service
  Box 6000
  Rockville, Maryland 20850
  (301) 251-5500

- American Correctional Association
  4321 Hartwick Road, Suite L-208
  College Park, Maryland 20740
  (301) 669-7600

- American Correctional Health Services Association
  5530 Wisconsin Avenue, N.W., Suite 745
  Washington, D.C. 20815
  (301) 652-1172

- National Institute of Corrections
  320 First Street, N.W.
  Washington, D.C. 20534
  (202) 724-3106

- National Institute of Corrections Information Center
  1790 30th Street
  Boulder, Colorado 80301
  (303) 444-1101

- National Institute of Corrections Jail Division
  1790 30th Street
  Boulder, Colorado 80301
  (303) 497-6700

- National Institute on Drug Abuse
  5600 Fishers Lane
  Rockville, Maryland 20857
  (301) 443-6500

- American Civil Liberties Union
  National Prison Project
  1616 P Street, N.W.
  Washington, D.C. 20036
  (202) 331-0500

3. Audio-Visual Materials

- "AIDS: A Bad Way To Die"
  Time: 40 minutes

  Charles Hernandez, Superintendent
  Taconic Correctional Facility
  250 Harris Road
  Bedford Hills, NY 10507
  (914) 241-3010

- "AIDS Questions and Answers"
  Time: 15 minutes

  Cermak Health Services
  2800 South California
  Chicago, IL 60608
  (312) 890-5640

- "Sex, Drugs, and AIDS"
  Time: 18 minutes

  ODN Productions
  74 Varick Street, Room 304
  New York, NY 10013
  (212) 431-8923

- "Beyond Fear"
  Time: 60 minutes

  American Red Cross General Supply Division
  7401 Lockport Place
  Lorton, VA 22079
  (703) 339-8890

- "Dying for Love - Women and AIDS"
  Time: 60 minutes

  Lifetime Public Affairs
  1211 Avenue of the Americas, 20th Floor
  New York, NY 10036
  (212) 719-8922

- "AIDS: Key Facts for Staff"
  Time: 36 minutes

"AIDS: Key Facts for Inmates"
Time: 30 minutes

Developed for the Federal Bureau of Prisons by:

Capitol Communication Systems, Inc.
#7 Chelsea House
2411 Crofton Lane
Crofton, MD 21114
(301) 261-6770

Contact: Tom Sutty

- "AIDS: The Challenge for Corrections"
  Time: 18 minutes

  "Preventing AIDS: It's a Matter of Life or Death" (available in Spanish)
  Time: 15 minutes,

  National Sheriffs Association
  1450 Duke Street
  Alexandria, VA 22314
  (703) 836-7827

- "AIDS: Key Facts for Correctional Staff"
  Time: 35 minutes

  "AIDS: Key Facts for Inmates"
  Time: 30 minutes

  American Correctional Association
  421 Hartwick Road
  College Park, MD 20740
  (301) 699-7650

APPENDIX B

Definitions of AIDS and AIDS-Related Complex

Reprinted by the
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL

from MMWR SUPPLEMENT, August 14, 1987, Vol. 36, No. 1S, pp. 3S–15S

Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome

Reported by
Council of State and Territorial Epidemiologists;
AIDS Program, Center for Infectious Diseases, CDC

INTRODUCTION

The following revised case definition for surveillance of acquired immunodeficiency syndrome (AIDS) was developed by CDC in collaboration with public health and clinical specialists. The Council of State and Territorial Epidemiologists (CSTE) has officially recommended adoption of the revised definition for national reporting of AIDS. The objectives of the revision are a) to track more effectively the severe disabling morbidity associated with infection with human immunodeficiency virus (HIV) (including HIV-1 and HIV-2); b) to simplify reporting of AIDS cases; c) to increase the sensitivity and specificity of the definition through greater diagnostic application of laboratory evidence for HIV infection; and d) to be consistent with current diagnostic practice, which in some cases includes presumptive, i.e., without confirmatory laboratory evidence, diagnosis of AIDS-indicative diseases (e.g., *Pneumocystis carinii* pneumonia, Kaposi's sarcoma).

The definition is organized into three sections that depend on the status of laboratory evidence of HIV infection (e.g., HIV antibody) (Figure 1). The major proposed changes apply to patients with laboratory evidence for HIV infection: a) inclusion of HIV encephalopathy, HIV wasting syndrome, and a broader range of specific AIDS-indicative diseases (Section II.A); b) inclusion of AIDS patients whose indicator diseases are diagnosed presumptively (Section II.B); and c) elimination of exclusions due to other causes of immunodeficiency (Section I.A).

Application of the definition for children differs from that for adults in two ways. First, multiple or recurrent serious bacterial infections and lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia are accepted as indicative of AIDS among children but not among adults. Second, for children<15 months of age whose mothers are thought to have had HIV infection during the child's perinatal period, the laboratory criteria for HIV infection are more stringent, since the presence of HIV antibody in the child is, by itself, insufficient evidence for HIV infection because of the persistence of passively acquired maternal antibodies < 15 months after birth.

The new definition is effective immediately. State and local health departments are requested to apply the new definition henceforth to patients reported to them. The initiation of the actual reporting of cases that meet the new definition is targeted for September 1, 1987, when modified computer software and report forms should be in place to accommodate the changes. CSTE has recommended retrospective application of the revised definition to patients already reported to health departments. The new definition follows:

1987 REVISION OF CASE DEFINITION FOR AIDS FOR SURVEILLANCE PURPOSES

For national reporting, a case of AIDS is defined as an illness characterized by one or more of the following "indicator" diseases, depending on the status of laboratory evidence of HIV infection, as shown below.

I. Without Laboratory Evidence Regarding HIV Infection

If laboratory tests for HIV were not performed or gave inconclusive results (*See* Appendix I) and the patient had no other cause of immunodeficiency listed in Section I.A below, then any disease listed in Section I.B indicates AIDS if it was diagnosed by a definitive method (*See* Appendix II).

A. **Causes of immunodeficiency that disqualify diseases as indicators of AIDS in the absence of laboratory evidence for HIV infection**
   1. high-dose or long-term systemic corticosteroid therapy or other immunosuppressive/cytotoxic therapy ≤3 months before the onset of the indicator disease
   2. any of the following diseases diagnosed ≤3 months after diagnosis of the indicator disease: Hodgkin's disease, non-Hodgkin's lymphoma (other than primary brain lymphoma), lymphocytic leukemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioimmunoblastic lymphadenopathy
   3. a genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome atypical of HIV infection, such as one involving hypogammaglobulinemia

B. **Indicator diseases diagnosed definitively (*See* Appendix II)**
   1. candidiasis of the esophagus, trachea, bronchi, or lungs
   2. cryptococcosis, extrapulmonary
   3. cryptosporidiosis with diarrhea persisting >1 month
   4. cytomegalovirus disease of an organ other than liver, spleen, or lymph nodes in a patient >1 month of age
   5. herpes simplex virus infection causing a mucocutaneous ulcer that persists longer than 1 month; or bronchitis, pneumonitis, or esophagitis for any duration affecting a patient >1 month of age
   6. Kaposi's sarcoma affecting a patient < 60 years of age
   7. lymphoma of the brain (primary) affecting a patient < 60 years of age
   8. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
   9. *Mycobacterium avium* complex or *M. kansasii* disease, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
   10. *Pneumocystis carinii* pneumonia
   11. progressive multifocal leukoencephalopathy
   12. toxoplasmosis of the brain affecting a patient >1 month of age

II. With Laboratory Evidence for HIV Infection

Regardless of the presence of other causes of immunodeficiency (I.A), in the presence of laboratory evidence for HIV infection (*See* Appendix I), any disease listed above (I.B) or below (II.A or II.B) indicates a diagnosis of AIDS.

A. Indicator diseases diagnosed definitively (*See* Appendix II)

1. bacterial infections, multiple or recurrent (any combination of at least two within a 2-year period), of the following types affecting a child < 13 years of age:

   septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses), caused by *Haemophilus*, *Streptococcus* (including pneumococcus), or other pyogenic bacteria

2. coccidioidomycosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
3. HIV encephalopathy (also called "HIV dementia," "AIDS dementia," or "subacute encephalitis due to HIV") (*See* Appendix II for description)
4. histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
5. isosporiasis with diarrhea persisting >1 month
6. Kaposi's sarcoma at any age
7. lymphoma of the brain (primary) at any age
8. other non-Hodgkin's lymphoma of B-cell or unknown immunologic phenotype and the following histologic types:
   a. small noncleaved lymphoma (either Burkitt or non-Burkitt type) (*See* Appendix IV for equivalent terms and numeric codes used in the *International Classification of Diseases*, Ninth Revision, Clinical Modification)
   b. immunoblastic sarcoma (equivalent to any of the following, although not necessarily all in combination: immunoblastic lymphoma, large-cell lymphoma, diffuse histiocytic lymphoma, diffuse undifferentiated lymphoma, or high-grade lymphoma) (*See* Appendix IV for equivalent terms and numeric codes used in the *International Classification of Diseases*, Ninth Revision, Clinical Modification)

   Note: Lymphomas are not included here if they are of T-cell immunologic phenotype or their histologic type is not described or is described as "lymphocytic," "lymphoblastic," "small cleaved," or "plasmacytoid lymphocytic"

9. any mycobacterial disease caused by mycobacteria other than *M. tuberculosis*, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
10. disease caused by *M. tuberculosis*, extrapulmonary (involving at least one site outside the lungs, regardless of whether there is concurrent pulmonary involvement)
11. *Salmonella* (nontyphoid) septicemia, recurrent
12. HIV wasting syndrome (emaciation, "slim disease") (*See* Appendix II for description)

B. Indicator diseases diagnosed presumptively (by a method other than those in Appendix II)

Note: Given the seriousness of diseases indicative of AIDS, it is generally important to diagnose them definitively, especially when therapy that would be used may have serious side effects or when definitive diagnosis is needed for eligibility for antiretroviral therapy. Nonetheless, in some situations, a patient's condition will not permit the performance of definitive tests. In other situations, accepted clinical practice may be to diagnose presumptively based on the presence of characteristic clinical and laboratory abnormalities. Guidelines for presumptive diagnoses are suggested in Appendix III.

1. candidiasis of the esophagus
2. cytomegalovirus retinitis with loss of vision
3. Kaposi's sarcoma
4. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
5. mycobacterial disease (acid-fast bacilli with species not identified by culture), disseminated (involving at least one site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
6. *Pneumocystis carinii* pneumonia
7. toxoplasmosis of the brain affecting a patient >1 month of age

III. With Laboratory Evidence Against HIV Infection

With laboratory test results negative for HIV infection (*See* Appendix I), a diagnosis of AIDS for surveillance purposes is ruled out *unless*:

A. all the other causes of immunodeficiency listed above in Section I.A are excluded; **AND**

B. the patient has had either:
  1. *Pneumocystis carinii* pneumonia diagnosed by a definitive method (*See* Appendix II); **OR**
  2. a. any of the other diseases indicative of AIDS listed above in Section I.B diagnosed by a definitive method (*See* Appendix II); **AND**
     b. a T-helper/inducer (CD4) lymphocyte count $<400/\text{mm}^3$.

COMMENTARY

The surveillance of severe disease associated with HIV infection remains an essential, though not the only, indicator of the course of the HIV epidemic. The number of AIDS cases and the relative distribution of cases by demographic, geographic, and behavioral risk variables are the oldest indices of the epidemic, which began in 1981 and for which data are available retrospectively back to 1978. The original surveillance case definition, based on then-available knowledge, provided useful epidemiologic data on severe HIV disease (*1*). To ensure a reasonable predictive value for underlying immunodeficiency caused by what was then an unknown agent, the indicators of AIDS in the old case definition were restricted to particular opportunistic diseases diagnosed by reliable methods in patients without specific known causes of immunodeficiency. After HIV was discovered to be the cause of AIDS, however, and highly sensitive and specific HIV-antibody tests became available, the spectrum of manifestations of HIV infection became better defined, and classification systems for HIV infection were developed (*2-5*). It became apparent that some progressive, seriously disabling, and even fatal conditions (e.g., encephalopathy, wasting syndrome) affecting a substantial number of HIV-infected patients were not subject to epidemiologic surveillance, as they were not included in the AIDS case definition. For reporting purposes, the revision adds to the definition most of those severe non-infectious, non-cancerous HIV-associated conditions that are categorized in the CDC clinical classification systems for HIV infection among adults and children (*4,5*).

Another limitation of the old definition was that AIDS-indicative diseases are diagnosed presumptively (i.e., without confirmation by methods required by the old definition) in 10%-15% of patients diagnosed with such diseases; thus, an appreciable proportion of AIDS cases were missed for reporting purposes (*6,7*). This proportion may be increasing, which would compromise the old case definition's usefulness as a tool for monitoring trends. The revised case definition permits the reporting of these clinically diagnosed cases as long as there is laboratory evidence of HIV infection.

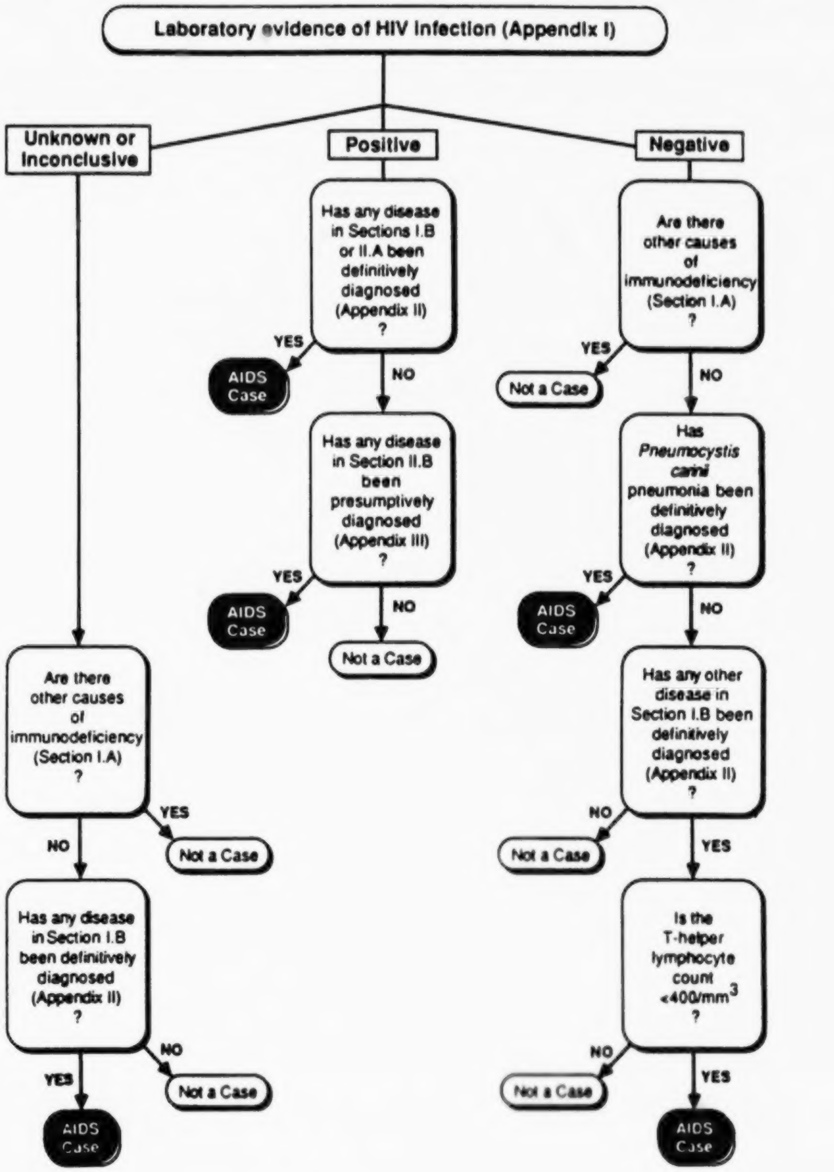
The effectiveness of the revision will depend on how extensively HIV-antibody tests are used. Approximately one third of AIDS patients in the United States have been from New York City and San Francisco, where, since 1985, < 7% have been reported with HIV-antibody test results, compared with > 60% in other areas. The impact of the revision on the reported numbers of AIDS cases will also depend on the proportion of AIDS patients in whom indicator diseases are diagnosed presumptively rather than definitively. The use of presumptive diagnostic criteria varies geographically, being more common in certain rural areas and in urban areas with many indigent AIDS patients.

To avoid confusion about what should be reported to health departments, the term "AIDS" should refer only to conditions meeting the surveillance definition. This definition is intended only to provide consistent statistical data for public health purposes. Clinicians will not rely on this definition alone to diagnose serious disease caused by HIV infection in individual patients because there may be additional information that would lead to a more accurate diagnosis. For example, patients who are not reportable under the definition because they have either a negative HIV-antibody test or, in the presence of HIV antibody, an opportunistic disease not listed in the definition as an indicator of AIDS nonetheless may be diagnosed as having serious HIV disease on consideration of other clinical or laboratory characteristics of HIV infection or a history of exposure to HIV.

Conversely, the AIDS surveillance definition may rarely misclassify other patients as having serious HIV disease if they have no HIV-antibody test but have an AIDS-indicative disease with a background incidence unrelated to HIV infection, such as cryptococcal meningitis.

The diagnostic criteria accepted by the AIDS surveillance case definition should not be interpreted as the standard of good medical practice. Presumptive diagnoses are accepted in the definition because not to count them would be to ignore substantial morbidity resulting from HIV infection. Likewise, the definition accepts a reactive screening test for HIV antibody without confirmation by a supplemental test because a repeatedly reactive screening test result, in combination with an indicator disease, is highly indicative of true HIV disease. For national surveillance purposes, the tiny proportion of possibly false-positive screening tests in persons with AIDS-indicative diseases is of little consequence. For the individual patient, however, a correct diagnosis is critically important. The use of supplemental tests is, therefore, strongly endorsed. An increase in the diagnostic use of HIV-antibody tests could improve both the quality of medical care and the function of the new case definition, as well as assist in providing counselling to prevent transmission of HIV.

FIGURE I. Flow diagram for revised CDC case definition of AIDS, September 1, 1987


Laboratory evidence of HIV infection (Appendix I)
Unknown or Inconclusive
Positive
Negative
Has any disease in Sections I.B or II.A been definitively diagnosed (Appendix II) ?
YES
AIDS Case
NO
Has any disease in Section II.B been presumptively diagnosed (Appendix III) ?
YES
AIDS Case
NO
Not a Case
Are there other causes of immunodeficiency (Section I.A) ?
YES
Not a Case
NO
Has Pneumocystis carinii pneumonia been definitively diagnosed (Appendix II) ?
YES
AIDS Case
NO
Has any other disease in Section I.B been definitively diagnosed (Appendix II) ?
NO
Not a Case
YES
Is the T-helper lymphocyte count <400/mm3 ?
NO
Not a Case
YES
AIDS Case
Are there other causes of immunodeficiency (Section I.A) ?
YES
Not a Case
NO
Has any disease in Section I.B been definitively diagnosed (Appendix II) ?
NO
Not a Case
YES
AIDS Case

References

1. World Health Organization. Acquired immunodeficiency syndrome (AIDS): WHO/CDC case definition for AIDS. WHO Wkly Epidemiol Rec 1986;61:69-72.
2. Haverkos HW, Gottlieb MS, Killen JY, Edelman R. Classification of HTLV-III/LAV-related diseases [Letter]. J Infect Dis 1985;152:1095.
3. Redfield RR, Wright DC, Tramont EC. The Walter Reed staging classification of HTLV-III infection. N Engl J Med 1986;314:131-2.
4. CDC. Classification system for human T-lymphotropic virus type III/lymphadenopathy-associated virus infections. MMWR 1986;35:334-9.
5. CDC. Classification system for human immunodeficiency virus (HIV) infection in children under 13 years of age. MMWR 1987;36:225-30,235.
6. Hardy AM, Starcher ET, Morgan WM, et al. Review of death certificates to assess completeness of AIDS case reporting. Pub Hlth Rep 1987;102(4):386-91.
7. Starcher ET, Biel JK, Rivera-Castano R, Day JM, Hopkins SG, Miller JW. The impact of presumptively diagnosed opportunistic infections and cancers on national reporting of AIDS [Abstract]. Washington, DC : III International Conference on AIDS, June 1-5, 1987.

APPENDIX I

Laboratory Evidence For or Against HIV Infection

1. **For Infection**:
   When a patient has disease consistent with AIDS:
   a. a serum specimen from a patient ≥15 months of age, or from a child <15 months of age whose mother is not thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test (e.g., enzyme-linked immunosorbent assay [ELISA]), as long as subsequent HIV-antibody tests (e.g., Western blot, immunofluorescence assay), if done, are positive; **OR**
   b. a serum specimen from a child < 15 months of age, whose mother is thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test (e.g., ELISA), plus increased serum immunoglobulin levels and at least one of the following abnormal immunologic test results: reduced absolute lymphocyte count, depressed CD4 (T-helper) lymphocyte count, or decreased CD4/CD8 (helper/suppressor) ratio, as long as subsequent antibody tests (e.g., Western blot, immunofluorescence assay), if done, are positive; **OR**
   c. a positive test for HIV serum antigen; **OR**
   d. a positive HIV culture confirmed by both reverse transcriptase detection and a specific HIV-antigen test or in situ hybridization using a nucleic acid probe; **OR**
   e. a positive result on any other highly specific test for HIV (e.g., nucleic acid probe of peripheral blood lymphocytes).

2. **Against Infection**:
   A nonreactive screening test for serum antibody to HIV (e.g., ELISA) without a reactive or positive result on any other test for HIV infection (e.g., antibody, antigen, culture), if done.

3. **Inconclusive (Neither For nor Against Infection)**:
   a. a repeatedly reactive screening test for serum antibody to HIV (e.g., ELISA) followed by a negative or inconclusive supplemental test (e.g., Western blot, immunofluorescence assay) without a positive HIV culture or serum antigen test, if done; **OR**
   b. a serum specimen from a child < 15 months of age, whose mother is thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test, even if positive by a supplemental test, without additional evidence for immunodeficiency as described above (in 1.b) and without a positive HIV culture or serum antigen test, if done.

APPENDIX II

Definitive Diagnostic Methods for Diseases Indicative of AIDS

Diseases	**Definitive Diagnostic Methods**
cryptosporidiosis cytomegalovirus isosporiasis Kaposi's sarcoma lymphoma lymphoid pneumonia or hyperplasia *Pneumocystis carinii* pneumonia progressive multifocal leukoencephalopathy toxoplasmosis	microscopy (histology or cytology).
candidiasis	gross inspection by endoscopy or autopsy or by microscopy (histology or cytology) on a specimen obtained directly from the tissues affected (including scrapings from the mucosal surface), not from a culture.
coccidioidomycosis cryptococcosis herpes simplex virus histoplasmosis	microscopy (histology or cytology), culture, or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues.
tuberculosis other mycobacteriosis salmonellosis other bacterial infection	culture.

HIV encephalopathy* (dementia)	clinical findings of disabling cognitive and/or motor dysfunction interfering with occupation or activities of daily living, or loss of behavioral developmental milestones affecting a child, progressing over weeks to months, in the absence of a concurrent illness or condition other than HIV infection that could explain the findings. Methods to rule out such concurrent illnesses and conditions must include cerebrospinal fluid examination and either brain imaging (computed tomography or magnetic resonance) or autopsy.
HIV wasting syndrome*	findings of profound involuntary weight loss >10% of baseline body weight plus either chronic diarrhea (at least two loose stools per day for ≥ 30 days) or chronic weakness and documented fever (for ≥ 30 days, intermittent or constant) in the absence of a concurrent illness or condition other than HIV infection that could explain the findings (e.g., cancer, tuberculosis, cryptosporidiosis, or other specific enteritis).

---

*For HIV encephalopathy and HIV wasting syndrome, the methods of diagnosis described here are not truly definitive, but are sufficiently rigorous for surveillance purposes.

APPENDIX III

Suggested Guidelines for Presumptive Diagnosis of Diseases Indicative of AIDS

Diseases	**Presumptive Diagnostic Criteria**
candidiasis of esophagus	a. recent onset of retrosternal pain on swallowing; **AND** b. oral candidiasis diagnosed by the gross appearance of white patches or plaques on an erythematous base or by the microscopic appearance of fungal mycelial filaments in an uncultured specimen scraped from the oral mucosa.
cytomegalovirus retinitis	a characteristic appearance on serial ophthalmoscopic examinations (e.g., discrete patches of retinal whitening with distinct borders, spreading in a centrifugal manner, following blood vessels, progressing over several months, frequently associated with retinal vasculitis, hemorrhage, and necrosis). Resolution of active disease leaves retinal scarring and atrophy with retinal pigment epithelial mottling.
mycobacteriosis	microscopy of a specimen from stool or normally sterile body fluids or tissue from a site other than lungs, skin, or cervical or hilar lymph nodes, showing acid-fast bacilli of a species not identified by culture.
Kaposi's sarcoma	a characteristic gross appearance of an erythematous or violaceous plaque-like lesion on skin or mucous membrane. (**Note**: Presumptive diagnosis of Kaposi's sarcoma should not be made by clinicians who have seen few cases of it.)
lymphoid interstitial pneumonia	bilateral reticulonodular interstitial pulmonary infiltrates present on chest X ray for ≥ 2 months with no pathogen identified and no response to antibiotic treatment.
Pneumocystis carinii pneumonia	a. a history of dyspnea on exertion or nonproductive cough of recent onset (within the past 3 months); **AND** b. chest X-ray evidence of diffuse bilateral interstitial infiltrates or gallium scan evidence of diffuse bilateral pulmonary disease; **AND** c. arterial blood gas analysis showing an arterial pO_2 of <70 mm Hg or a low respiratory diffusing capacity ($<80\%$ of predicted values) or an increase in the alveolar-arterial oxygen tension gradient; **AND** d. no evidence of a bacterial pneumonia.

toxoplasmosis of the brain	a. recent onset of a focal neurologic abnormality consistent with intracranial disease or a reduced level of consciousness; **AND** b. brain imaging evidence of a lesion having a mass effect (on computed tomography or nuclear magnetic resonance) or the radiographic appearance of which is enhanced by injection of contrast medium; **AND** c. serum antibody to toxoplasmosis or successful response to therapy for toxoplasmosis.

APPENDIX IV

Equivalent Terms and International Classification of Disease (ICD) Codes for AIDS-Indicative Lymphomas

The following terms and codes describe lymphomas indicative of AIDS in patients with antibody evidence for HIV infection (Section II.A.8 of the AIDS case definition). Many of these terms are obsolete or equivalent to one another.

ICD-9-CM (1978)

Codes	Terms
200.0	**Reticulosarcoma** lymphoma (malignant): histiocytic (diffuse) reticulum cell sarcoma: pleomorphic cell type or not otherwise specified
200.2	**Burkitt's tumor or lymphoma** malignant lymphoma, Burkitt's type

ICD-O (Oncologic Histologic Types 1976)

Codes	Terms
9600/3	**Malignant lymphoma, undifferentiated cell type** non-Burkitt's or not otherwise specified
9601/3	**Malignant lymphoma, stem cell type** stem cell lymphoma
9612/3	**Malignant lymphoma, immunoblastic type** immunoblastic sarcoma, immunoblastic lymphoma, or immunoblastic lymphosarcoma
9632/3	**Malignant lymphoma, centroblastic type** diffuse or not otherwise specified, or germinoblastic sarcoma: diffuse or not otherwise specified
9633/3	**Malignant lymphoma, follicular center cell, non-cleaved** diffuse or not otherwise specified
9640/3	**Reticulosarcoma, not otherwise specified** malignant lymphoma, histiocytic: diffuse or not otherwise specified reticulum cell sarcoma, not otherwise specified malignant lymphoma, reticulum cell type
9641/3	**Reticulosarcoma, pleomorphic cell type** malignant lymphoma, histiocytic, pleomorphic cell type reticulum cell sarcoma, pleomorphic cell type
9750/3	**Burkitt's lymphoma or Burkitt's tumor** malignant lymphoma, undifferentiated, Burkitt's type malignant lymphoma, lymphoblastic, Burkitt's type

NIH's DEFINITION OF AIDS-RELATED COMPLEX

At least 2 of the following clinical signs/symptoms lasting 3 or more months PLUS 2 or more of the following laboratory abnormalities, occurring in a patient having no underlying infectious cause for the symptoms and who is in a cohort at increased risk for developing AIDS.

Clinical:

1. Fever: >100°F, intermittent or continuous, for at least 3 months, in the absence of other identifiable causes.
2. Weight Loss: 10% or ≥15 lbs.
3. Lymphadenopathy: persistent for at least 3 months, involving ≥2 extra-inguinal node bearing areas.
4. Diarrhea: intermittent or continuous, ≥3 months, in the absence of other identifiable causes.
5. Fatigue, to the point of decreased physical or mental function.
6. Night Sweats: intermittent or continuous, ≥3 months, in the absence of other identifiable causes

Laboratory:

1. Depressed helper T-cells (≥2 standard deviations below mean).
2. Depressed helper/suppressor ratio (≥2 standard deviations below mean).
3. At least one of the following: leukopenia, thrombocytopenia, absolute lymphopenia or anemia.
4. Elevated serum globulins.
5. Depressed blastogenesis (pokeweed and PHA).
6. Abnormal skin tests (using Multi-Test or equivalent).

APPENDIX C

List of City and County Jail Systems
and
List of Canadian Systems
Responding to the
NIJ Survey

LIST OF CITY AND COUNTY JAIL SYSTEMS RESPONDING TO NIJ SURVEY

1. Arizona, Maricopa (Phoenix) County Jail
2. California, Alameda County (Oakland) Sheriff's Department
3. California, Contra Costa County Sheriff's Department
4. California, Los Angeles County Sheriff's Department
5. California, Orange County Sheriff's Department
6. California, Riverside County Sheriff's Department
7. California, Sacramento County Sheriff's Department
8. California, San Bernardino County Sheriff's Department
9. California, San Diego County Sheriff's Department
10. California, San Francisco County Sheriff's Department
11. California, Santa Clara County Sheriff's Department
12. California, Ventura County Sheriff's Department
13. Colorado, Denver County Jail
14. District of Columbia, Department of Corrections
15. Florida, Broward County (Fort Lauderdale) Jail
16. Florida, Dade County (Miami) Corrections and Rehabilitation Department
17. Georgia, Fulton County (Atlanta) Jail
18. Illinois, Cook County (Chicago) Department of Corrections
19. Indiana, Marion County (Indianapolis) Sheriff's Department
20. Kentucky, Jefferson County (Louisville) Corrections Department
21. Maryland, Baltimore City Jail
22. Massachusetts, Suffolk County (Boston) Sheriff's Department
23. Minnesota, Hennepin County (Minneapolis) Sheriff's Department
24. Michigan, Wayne County (Detroit) Sheriff's Department
25. Missouri, Jackson County (Kansas City) Department of Corrections
26. New Jersey, Essex County (Newark) Jail
27. New Jersey, Hudson (Jersey City) Jail
28. New York City, Department of Corrections
29. New York, Westchester County Department of Corrections
30. Pennsylvania, Allegheny County (Pittsburgh) Jail
31. Pennsylvania, Philadelphia Department of Human Services
32. Texas, Harris County (Houston) Central Jail
33. Washington, Seattle Department of Adult Detention

144

LIST OF CANADIAN SYSTEMS
RESPONDING TO NIJ SURVEY

1. Correctional Service of Canada, Ottawa (federal system)
2. Alberta Correctional Service Edmonton
3. British Columbia Correctional Headquarters, Vancouver
4. Manitoba Community Services, Department of Corrections, Winnipeg
5. New Brunswick, Fredericton Provincial Jail
6. Northwest Territories, Yellowknife Correctional Center
7. Nova Scotia Correctional Services, Halifax
8. Newfoundland and Labrador, Department of Justice, St. John's
9. Ontario, Ministry of Correctional Services, Scarborough
10. Quebec Correctional Services, Quebec City
11. Saskatchewan Department of Corrections, Regina
12. Yukon Territory, Whitehorse Correctional Center

APPENDIX D

Training, Education and Counseling Materials

- *Staff Training Materials*
- *Inmate Training Materials*
- *Curriculum for Staff and Inmates*
- *Posters*
- *Counseling Materials*
- *Pre/Post Test of AIDS Knowledge*

Staff Training Materials

TEXAS DEPARTMENT
OF
CORRECTIONS

IN-SERVICE TRAINING
DIVISION

Course Title In-Service Training Division

Lesson Title AIDS

Instructor(s) In-Service Training Staff

Prepared By In-Service Staff Date September, 1987

Time Frame

Total: ______ Hrs., _____ Min.

Target Population
TDC Employees
Number of Participants
30-50
Space Requirements
Large Classroom

PERFORMANCE OBJECTIVES:
Upon completion of this period of instruction, the employee will be able to:

1. Define the functional role of the Centers for Disease Control.
2. Identify four (4) areas which the Center for Disease Control assists local, county and state health agencies.
3. Define the relationship between the Unit Warden and the Unit Health Administrator in assessing AIDS related policy for unit personnel.
4. List the responsibilities of the Coordinator for Infectious Diseases (CID).
5. Identify who is responsible for coordinating AIDS training or retraining for unit personnel.
6. Identify specific practices correctional officers should follow when making cell/body searches.
7. Identify the established precautionary procedures for performing CPR.
8. Identify the procedures to be used when handling equipment contaminated with blood or other body fluids (i.e., handcuffs, leg irons, etc.).

EVALUATION PROCEDURES:
Written Examination

LESSON PLAN COVER SHEET - PAGE 2

Methods

Lecture

Group Discussion

Instructor Materials

Lesson Plan

Equipment and Supplies Needed

_X_ Flipchart holder
___ Chalkboard
___ 16mm Projector
Film length: ___ min.
___ Slide Projector
Type: Carousel ___
Tray ___
Sound-on-Slide
_X_ Flipchart
___ Felt-tip marker
___ Masking tape
Other __________

___ Videotape player
Type: ___ " open real
___ 3/4 cassette
___ Betamax
Video tape length: ___ minutes
___ Video tape recorder with camera
___ Public address system
___ Overhead Projector

Student Materials (Handouts)

Title	# Needed from TDC	When Distributed	Comments
Acquired Immune Deficiency Syndrome (AIDS) Questions and Answers -- Correctional/Law Enforcement Issues			

* It is expected you will secure copyright clearances unless otherwise indicated.

REFERENCES:

Administrative Directive 06.60 (rev. 3)
Health Services Policy 2-18
Health Services Policy 3-21A
Health Services Policy 3-39
Health Services Policy 3-40
Health Services Policy 3-41
AIDS: Improving the Response of the Correctional System; National Sheriffs' Association, 1986.
AIDS In Corrections Facilities: Issues and Options; National Institute of Justice, Second Edition, 1987.

LESSON PLAN COVER SHEET - PAGE 3

CONTINUATION PAGE

9. List the disinfectants that may be used on equipment that has become soiled with contaminated materials.
10. List two additional measures used to kill the AIDS virus on equipment or clothing.
11. Identify when staff or inmates may use disposable plastic gloves.
12. List the procedures that are applicable when using disposable plastic gloves.
13. List the standard procedure staff should use when they must clean up after any accident or injury.
14. Identify when gowns and gloves are made available to staff.
15. Identify what types of protective equipment is used in case of respiratory infection or other potentially airborne diseases.
16. List protective equipment staff are required to utilize during a use of force incident.
17. Identify what action a correctional officer must take if he observes an inmate exhibiting violent or intimidating behavior toward another inmate.
18. Identify who a correctional officer must report to when he observes signs or illness in inmates or staff.

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course: ____________

Date issued: ____________ Page 1 of 21

Supersedes issue date: ____________

Approved By: ____________

INSTRUCTOR'S NOTES

OUTLINE

I. INTRODUCTION

PRESENTLY, THE U.S. SURGEON GENERAL ESTIMATES THAT APPROXIMATELY 1.5 MILLION AMERICANS ARE INFECTED WITH THE AIDS VIRUS. PRISON INMATES BECAUSE THEY ARE CONFINED AND HAVE A HIGHER INCIDENCE OF HIGH-RISK INDIVIDUALS THAN THE GENERAL POPULATION, REQUIRE SPECIAL PRECAUTIONARY MEASURES. OUR INMATE POPULATION INCLUDES RELATIVELY LARGE NUMBERS OF DRUG ABUSERS AND INDIVIDUALS WHO HAVE ENGAGED IN HOMOSEXUAL ACTIVITY.

IN THE ABSENCE OF KNOWING AT ANY GIVEN TIME WHETHER AN INMATE IS OR IS NOT INFECTED WITH THE AIDS VIRUS, STAFF AND INMATES MUST TAKE FULL PRECAUTIONARY MEASURES WHEN CARING FOR, TREATING OR CLEANING UP BLOOD OR BODY FLUIDS OF ALL INMATES.

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course: __________

Date issued: __________ Page 4 of 23

Supersedes issue date: __________

Approved By: __________

INSTRUCTOR'S NOTES

OUTLINE

IN THIS BLOCK OF INSTRUCTION, WE WILL DISCUSS: (1) THE UNITED STATES CENTER FOR DISEASE CONTROL AND ITS GUIDELINES FOR THOSE WHO CARE FOR OR MAY COME IN CONTACT WITH THE BLOOD/BODY FLUIDS OF INDIVIDUALS INFECTED WITH THE AIDS VIRUS; (2) INFECTION CONTROL ADMINISTRATIVE AND PRACTICES; (3) SPECIAL CLOTHING AND PROTECTIVE EQUIPMENT FOR STAFF; AND (4) REPORTING GUIDELINES.

II. BRIEFLY DISCUSS PERFORMANCE OBJECTIVES

III. CENTERS FOR DISEASE CONTROL (CDC)

THE CENTER FOR DISEASE CONTROL IS THE DIRECT DESCENDANT OF A WORLD WAR II AGENCY -- MALARIA CONTROL IN WAR AREAS (MCWA). THE CDC WAS BUILT AROUND THE NUCLEUS OF MCWA'S DISEASE CONTROL SPECIALISTS AND WAS

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course:

Date issued: Page 5 of 23

Supersedes issue date:

Approved By:

INSTRUCTOR'S NOTES

OUTLINE

CREATED TO BE A CENTER OF EXCELLENCE TO LEAD THE NATION'S ATTACK ON COMMUNICABLE DISEASE. THE CDC IS A FEDERALLY FUNDED AGENCY WHICH IS RESPONSIBLE FOR SAFEGUARDING THE HEALTH OF THE AMERICAN PEOPLE BY CONTROLLING OR PREVENTING DISEASE. IN 1970 THE CENTER WAS RENAMED THE CENTER FOR DISEASE CONTROL TO REFLECT THE EXPANSION OF THE AGENCY. BECAUSE THE CDC HAS RESPONSIBILITY FOR INFECTION CONTROL MANAGEMENT, IT IS THE PRIMARY SOURCE FOR DISSEMINATION OF INFORMATION ON THE AIDS VIRUS.

A. THE CENTERS FOR DISEASE CONTROL (CDC) SERVE AS THE NATIONAL FOCUS FOR DEVELOPING AND APPLYING DISEASE PREVENTION AND CONTROL, ENVIRONMENTAL HEALTH, AND HEALTH

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course:

Date issued: Page 6 of 23

Supersedes issue date:

Approved By:

INSTRUCTOR'S NOTES

OUTLINE

PROMOTION AND EDUCATION ACTIVITIES DESIGNED TO IMPROVE THE HEALTH OF THE PEOPLE OF THE UNITED STATES.

B. CDC IS RESPONSIBLE FOR CONTROLLING THE INTRODUCTION AND SPREAD OF INFECTIOUS DISEASES, AND PROVIDES CONSULTATION AND ASSISTANCE TO OTHER NATIONAL AND INTERNATIONAL AGENCIES TO ASSIST IN IMPROVING THEIR DISEASE PREVENTION AND CONTROL, ENVIRONMENTAL HEALTH AND HEALTH PROMOTION ACTIVITIES.

C. A MAJOR CDC ACTIVITY CONTINUES TO BE TRACKING DISEASE INCIDENCE AND TRENDS. IT EXCHANGES EPIDEMIOLOGICAL INFORMATION WITH HEALTH AUTHORITIES THROUGHOUT THE WORLD TO ENABLE THEM TO TAKE QUICK ACTION AS PROBLEMS ARISE AND ARE IDENTIFIED. IN

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course: ____

Date issued: ____ Page 7 of 23

Supersedes issue date: ____

Approved By: ____

INSTRUCTOR'S NOTES	OUTLINE
	THIS COUNTRY, CDC WORKS CLOSELY WITH STATE AND LOCAL HEALTH DEPARTMENTS IN DEVELOPING AND OPERATING DISEASE CONTROL PROGRAMS FOR VENEREAL DISEASE CONTROL, CHILDHOOD IMMUNIZATION, CHILDHOOD LEAD POISONING PREVENTION AND COMMUNITY WATER FLUORIDATION.
EMPHASIZE THAT THESE GUIDELINES ARE GENERAL. THE UNIT WARDEN AND THE UNIT HEALTH AUTHORITY ESTABLISH UNIT POLICY. REFER TO AD-06.60, ATTACHMENT A, #1.	IV. INFECTION CONTROL - ADMINISTRATION A. WITH THE ASSISTANCE OF THE UNIT HEALTH AUTHORITY OR DESIGNEE, EACH WARDEN REVIEWS ASPECTS OF THE INSTITUTION'S OPERATIONS INCLUDING SECURITY, LAUNDRY, WORK AREAS, FOOD SERVICES, VISITING, BARBER SERVICES, RECREATION, TRANSPORTATION AND MAINTENANCE TO ASSESS AREAS WHERE IMPROVEMENTS CAN BE MADE TO REDUCE THE RISK OF TRANSMISSION OF INFECTIOUS DISEASES.

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course:

Date issued: Page 8 of 23

Supersedes issue date:

Approved By:

INSTRUCTOR'S NOTES	OUTLINE
	PARTICULAR ATTENTION WILL BE GIVEN TO CIRCUMSTANCES WHERE THE POTENTIAL EXISTS FOR SOMEONE TO COME IN CONTACT WITH THE BODY FLUIDS OF ANOTHER.
REFER TO AD-06.60, SECTION II.C.	B. EACH UNIT SHALL DESIGNATE A NURSE WHO WILL SERVE AS A COORDINATOR OF INFECTIOUS DISEASES (CID). THE CID WILL BE THE FOCAL POINT FOR THE DISSEMINATION OF INFORMATION ON INFECTIOUS DISEASES. IT WILL BE THE RESPONSIBILITY OF THE CID TO INSURE APPROPRIATE REPORTING OF AIDS INFORMATION AND STATISTICS TO CENTRAL OFFICES AS WELL AS MONITORING COMPLIANCE WITH DEPARTMENTAL POLICIES AND PROCEDURES. THE CID WILL ALSO COORDINATE TRAINING NEEDS WITH THE MEDICAL TRAINING AND

IN-SERVICE TRAINING TEXAS DEPARTMENT OF CORRECTIONS Training Division	SUBJECT AIDS Hours required for course: Date issued: Page 9 of 23 Supersedes issue date: Approved By:

INSTRUCTOR'S NOTES

EXPLAIN THE DIFFERENCE BETWEEN THE UHA, CID AND PHN.

OUTLINE

CONTINUING EDUCATION DEPARTMENT OF THE HEALTH SERVICES DIVISION.

C. IT IS THE RESPONSIBILITY OF THE WARDEN ON EACH UNIT (WITH THE ASSISTANCE OF THE PUBLIC HEALTH NURSE AND THE MEDICAL TRAINING AND CONTINUING EDUCATION STAFF) TO INSURE THAT IN-SERVICE TRAINING ON AIDS AND/OR AIDS LITERATURE IS PROVIDED TO BOTH STAFF AND INMATES ON A REGULAR BASIS.

V. INFECTION CONTROL - PRACTICES

FOLLOWING ARE GUIDELINES AND PRECAUTIONARY PRACTICES SECURITY OFFICERS SHOULD OBSERVE DURING THEIR TOUR OF DUTY:

A. CELL AND BODY SEARCHES

1. MAKE SURE ANY OPEN WOUNDS AND SORES ARE COVERED WITH CLEAN

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course:

Date issued: Page 10 of 23

Supersedes issue date:

Approved By:

INSTRUCTOR'S NOTES	OUTLINE
	BANDAGES TO PREVENT POSSIBLE EXCHANGE OF BLOOD. 2. WEAR PROTECTIVE GLOVES IF THERE IS A CHANCE OF CONTACT WITH BLOOD OR BODY FLUIDS (URINE, SALIVA, FECES, VOMIT) ON AN INMATE, CLOTHING OR LINEN. 3. AVOID NEEDLE STICKS OR PUNCTURES WITH ANY SHARP OBJECTS (E.G., KNIVES OR RAZORS THAT MAY BE CONTAMINATED WITH BLOOD) ON THE INMATE'S BODY. 4. NEVER BLINDLY PLACE HANDS IN AREAS WHERE THERE MAY BE SHARP OBJECTS THAT COULD CUT OR PUNCTURE THE SKIN, AND BE PARTICULARLY ALERT FOR SUCH OBJECTS DURING CELL SEARCHES.

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course:

Date issued: Page 11 of 23

Supersedes issue date:

Approved By:

INSTRUCTOR'S NOTES

OUTLINE

5. WASH HANDS WITH SOAP AND WARM WATER FOLLOWING EVERY SEARCH.

B. PROCEDURES FOR FIRST AID AND CPR

1. MOUTHPIECES, RESUSCITATION BAGS AND OTHER VENTILATION DEVICES WILL BE MADE AVAILABLE TO MINIMIZE THE NEED FOR EMERGENCY MOUTH-TO-MOUTH RESUSCITATION.

2. SPECIAL POCKET MASKS WITH ONE-WAY AIR TUBES WILL BE AVAILABLE TO PREVENT CONTACT WITH SALIVA SHOULD MOUTH-TO-MOUTH RESUSCITATION BE NECESSARY.

3. CORRECTIONAL OFFICERS SHOULD CHECK WITH THE UNIT SECURITY STAFF AND UNIT HEALTH AUTHORITY FOR THE LOCATION OF THESE ITEMS

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course:

Date issued: Page 12 of 23

Supersedes issue date:

Approved By:

INSTRUCTOR'S NOTES	OUTLINE
	WHICH CAN BE USED FOR FIRST AID AND CPR. C. CONTAMINATED EQUIPMENT OR SPILLS OF BODY FLUIDS 1. EQUIPMENT CONTAMINATED WITH BLOOD OR OTHER BODY FLUIDS OF ANY PERSON, REGARDLESS OF HIV INFECTION STATUS, SHOULD BE CLEANED WITH SOAP AND WATER. A HOSPITAL DISINFECTANT OR A FRESHLY PREPARED SOLUTION OF SODIUM HYPOCHLORITE (ONE PART HOUSEHOLD BLEACH TO TEN PARTS WATER) SHOULD BE USED TO WIPE THE AREA AFTER CLEANING. 2. SECURITY EQUIPMENT (I.E., HANDCUFFS) THAT COME IN CONTACT WITH BLOOD OR OTHER SECRETIONS SHOULD BE WASHED AND DISINFECTED.

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course: ____

Date issued: ____ Page 13 of 23

Supersedes issue date: ____

Approved By: ____

INSTRUCTOR'S NOTES	OUTLINE
	3. ADDITIONALLY, THE AIDS VIRUS CAN BE KILLED BY A 40 TO 70 PER CENT ALCOHOL-WATER MIXTURE, HYDROGEN PEROXIDE, HEAT FROM CLOTHES OR HAIR DRYERS AND EXPOSURE TO SUNLIGHT. 4. EACH WORK AREA WITHIN THE INSTITUTION SHALL BE PROVIDED DISPOSABLE PLASTIC GLOVES (HOSPITAL TYPE) FOR USE BY STAFF MEMBERS AT THEIR DISCRETION. THEY CAN BE DISPOSED OF WITH THE NORMAL TRASH UNLESS THEY ARE CONTAMINATED WITH BLOOD OR BODY FLUIDS, WHICH SHOULD BE DISPOSED OF ACCORDING TO INFECTION CONTROL PROCEDURES OUTLINED IN HEALTH SERVICES

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course:

Date issued: Page 14 of 23

Supersedes issue date:

Approved By:

INSTRUCTOR'S NOTES	OUTLINE

POLICIES AND PROCEDURES.

5. THE HOSPITAL TYPE DISPOSABLE EXAMINATION GLOVE WILL ALSO BE AVAILABLE FOR USE BY STAFF IN IN CASES WHEN IT IS NECESSARY TO HANDLE OR CLEAN UP BLOOD OR BODY FLUIDS. ONCE USED, THEY SHOULD BE TREATED AS CONTAMINATED AND DISPOSED OF ACCORDING TO INFECTION CONTROL PROCEDURES, ALONG WITH ALL MATERIALS USED IN THE CLEANUP PROCESS.

D. GENERAL INFECTION CONTROL GUIDELINES

1. WEARING OF GLOVES, ESPECIALLY WHEN PERSONNEL HAVE OPEN LESIONS ON THEIR HANDS.
2. BLOOD AND BODY FLUID SPILLS SHOULD BE CLEANED UP SOON

IN-SERVICE TRAINING

TEXAS DEPARTMENT OF CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course:

Date issued: Page 15 of 23

Supersedes issue date:

Approved By:

INSTRUCTOR'S NOTES

OUTLINE

AFTER THE SPILL WITH A DISPOSABLE TOWEL.

3. FOLLOWING A BODY FLUID SPILL, THE ENVIRONMENTAL SURFACE SHOULD BE CLEANED UP WITH A FRESHLY PREPARED BLEACH IN WATER SOLUTION (AT LEAST A 1 TO 10 DILUTION OF BLEACH IN WATER) OR ANOTHER DISINFECTANT.
4. BLOOD (OR BODY FLUID) SOAKED ITEMS THAT ARE DISPOSABLE SHOULD BE PLACED IN A STURDY PLASTIC BAG, SEALED AND MARKED "BLOOD AND BODY FLUID PRECAUTIONS". PERSONS DISPOSING OF THE PLASTIC BAG SHOULD WEAR GLOVES.
5. PERSONS CLEANING UP SPILLS OR HANDLING CONTAMINATED ITEMS

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course: ____

Date issued: ____ Page 16 of 23

Supersedes issue date: ____

Approved By: ____

INSTRUCTOR'S NOTES	OUTLINE
	SHOULD WASH THEIR HANDS AFTER SUCH ACTIVITIES, EVEN IF THEY HAD BEEN WEARING GLOVES. 6. CLOTHES AND LINENS CONTAMINATED WITH BODY FLUIDS SHOULD BE PLACED IN A WATER SOLUBLE BAG AND THEN IN A PLASTIC BAG AND LAUNDERED SEPARATELY. PERSONS HANDLING CONTAMINATED CLOTHING SHOULD WEAR GLOVES. 7. PERSONS WHOSE CLOTHES HAVE BEEN CONTAMINATED WITH BODY FLUIDS OF ANOTHER PERSON SHOULD BE PROVIDED A CHANGE OF CLOTHES AND AN OPPORTUNITY TO WASH AS SOON AS POSSIBLE.

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course: ________

Date issued: ________ Page 17 of 23

Supersedes issue date: ________

Approved By: ________

INSTRUCTOR'S NOTES	OUTLINE

8. ANY PERSON THAT HAS HAD A SIGNIFICANT EXPOSURE (SPLASHING OF BODY FLUID INTO THE EYE, MOUTH OR AN OPEN LESION, PUNCTURE WITH AN ITEM CONTAMINATED WITH A BODY FLUID OR A BITE) SHOULD CONSULT WITH THE HEALTH SERVICE UNIT STAFF REGARDING THE EXPOSURE AND POTENTIAL FOLLOW-UP RECOMMENDATIONS.

VI. SPECIAL CLOTHING AND PROTECTIVE EQUIPMENT FOR STAFF

A. GLOVES AND GOWNS WILL BE MADE AVAILABLE TO ALL STAFF WHEN THERE IS POTENTIAL FOR CONTACT WITH BLOOD OR BODY FLUIDS. EACH WORK AREA WITHIN THE INSTITUTION SHALL BE PROVIDED

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course: ________

Date issued: ________ Page 18 of 23

Supersedes issue date: ________

Approved By: ________

INSTRUCTOR'S NOTES	OUTLINE

DISPOSABLE PLASTIC GLOVES (HOSPITAL TYPE) FOR USE BY STAFF MEMBERS AT THEIR DISCRETION. THE HOSPITAL TYPE DISPOSABLE EXAMINATION GLOVE WILL ALSO BE AVAILABLE FOR USE BY STAFF AND INMATES IN CASES WHEN IT IS NECESSARY TO HANDLE OR CLEAN UP BLOOD AND BODY FLUIDS.

B. MASKS WILL BE MADE AVAILABLE FOR STAFF AND PATIENTS IN THE CASE OF RESPIRATORY INFECTION OR OTHER POTENTIALLY AIRBORNE DISEASE.

C. MOUTHPIECES, RESUSCITATION BAGS AND OTHER VENTILATION DEVICES WILL BE MADE AVAILABLE TO MINIMIZE THE NEED FOR EMERGENCY MOUTH-TO-MOUTH RESUSCITATION. SPECIAL POCKET MASKS WITH ONE-WAY AIR TUBES WILL BE AVAILABLE TO PREVENT CONTACT

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course:

Date issued: Page 19 of 23

Supersedes issue date:

Approved By:

INSTRUCTOR'S NOTES

BE ALERT; FOLLOW GOOD SECURITY PROCEDURES!

OUTLINE

WITH SALIVA SHOULD MOUTH-TO-MOUTH RESUSCITATION BE NECESSARY.

D. SPECIAL ATTENTION MUST BE GIVEN DURING USE OF FORCE INCIDENTS TO INSURE STAFF ARE REQUIRED TO UTILIZE FACE SHIELDS, GLOVES AND PROTECTIVE CLOTHING WHEN CONTACT WITH BLOOD OR BODY FLUIDS IS ANTICIPATED. CORRECTIONAL STAFF SHOULD RELY ON THE GUIDANCE OF THEIR UNIT'S INSTITUTION'S PROCEDURAL GUIDELINES FOR SPECIFIC PROTECTIVE EQUIPMENT TO BE USED IN USE OF FORCE INCIDENTS.

VII. REPORTING GUIDELINES

A. THE INMATE SUSPECTED OF OR DIAGNOSED WITH AIDS MAY BE THE VICTIM OF THREATS, VIOLENCE, OR INTIMIDATION, ESPECIALLY IF HE OR SHE IS HOUSED WITH THE

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course: __________

Date issued: __________ Page 20 of 23

Supersedes issue date: __________

Approved By: __________

INSTRUCTOR'S NOTES

OUTLINE

GENERAL INMATE POPULATION. THE CORRECTIONAL OFFICER IS IN A POSITION TO BE AWARE OF THE TENDENCY OF OTHER INMATES TO BEHAVE IN A POTENTIALLY HARMFUL MANNER. THESE ACTIONS SHOULD BE REPORTED TO THE SUPERVISOR, AND APPROPRIATE ACTION SHOULD BE TAKEN TO PROTECT THE AFFECTED INMATE.

B. OFFICERS NEED TO UNDERSTAND THAT BECAUSE OF THEIR GREATLY SUPPRESSED IMMUNE SYSTEMS, AIDS-INFECTED PERSONS ARE HIGHLY SUSCEPTIBLE TO INFECTIOUS DISEASES THAT MAY NOT AFFECT A HEALTHY IMMUNE SYSTEM. THEREFORE, EVEN MILD VIRUSES CARRIED BY OTHER INMATES OR STAFF MEMBERS COULD RESULT IN LIFE-THREATENING ILLNESSES TO THE PERSON WITH AIDS. WHEN NECESSARY

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course: ____

Date issued: ____ Page 21 of 23

Supersedes issue date: ____

Approved By: ____

INSTRUCTOR'S NOTES	OUTLINE
	THE OFFICER MUST TAKE STEPS TO PROTECT THE INFECTED PERSON BOTH FROM CONTACTS WITH OTHERS WHO ARE ILL OR FROM AGGRESSIVE OR HOSTILE INMATES. VIII. SUMMARY A. CORRECTIONAL OFFICERS HAVE MANY COMPLEX RESPONSIBILITIES THAT MAY BRING THEM INTO CLOSE, DAILY CONTACT WITH PERSONS SUSPECTED OF OR DIAGNOSED WITH AIDS. IN PARTICULAR, OFFICERS MUST EFFECTIVELY MANAGE AND BE KNOWLEDGEABLE OF THE FOLLOWING SITUATIONS: 1. GENERAL INFECTION CONTROL GUIDELINES AS ESTABLISHED BY THE CENTER FOR DISEASE CONTROL; 2. THE DEPARTMENT'S RESPONSIBILITIES IN

IN-SERVICE TRAINING

TEXAS DEPARTMENT
OF
CORRECTIONS

Training Division

SUBJECT AIDS

Hours required for course: ____

Date issued: ____ Page 22 of 23

Supersedes issue date: ____

Approved By: ____

INSTRUCTOR'S NOTES

OUTLINE

INFECTION CONTROL;

3. UNIT INFECTION CONTROL PRACTICES TO INCLUDE:

   a. DISINFECTANT MEASURES
   b. WHAT TO DO WITH CONTAMINATED EQUIPMENT
   c. ALLOWABLE SPECIAL CLOTHING/ PROTECTIVE EQUIPMENT
   d. DISPOSAL PROCEDURES FOR CONTAMINATED EQUIPMENT/ CLOTHING
   e. PRECAUTIONS WHEN PERFORMING BODY AND/OR CELL SEARCHES
   f. PROCEDURES WHEN ADMINISTERING CPR OR FIRST AID
   g. SPECIFIC PRACTICES TO USE DURING AN INMATE DISTURBANCE WHEN A USE OF FORCE IS IMMINENT
   h. PRACTICES TO EMPLOY AT THE SCENE OF A HOMICIDE OR SUICIDE

IN-SERVICE TRAINING TEXAS DEPARTMENT OF CORRECTIONS Training Division	SUBJECT AIDS Hours required for course: Date issued: Page 23 of 23 Supersedes issue date: Approved By:

INSTRUCTOR'S NOTES	OUTLINE
	i. PROCEDURES FOR THE CLEANING OF BLOOD OR BODY FLUID SPILLS B. IT IS IMPORTANT TO REMEMBER THAT YOU CAN RESPOND EFFECTIVELY IN ANY SITUATION IF YOU ARE KNOWLEDGEABLE OF THE CORRECT PROCEDURES THAT MUST BE USED. ALWAYS FOLLOW INFECTION CONTROL GUIDELINES. IF A SITUATION ARISES THAT YOU ARE NOT FAMILIAR WITH, SEEK GUIDANCE FROM YOUR SHIFT SUPERVISOR AND/OR UNIT ADMINISTRATIVE STAFF.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Questions And Answers--Correctional/Law Enforcement Issues

1. As a correctional officer, what do I do if blood, semen, spit, feces, vomit, or urine is thrown in my face, on my body, or on my clothing?

   Viruses do not penetrate intact skin. Wash your body with soap and water as soon as possible. If your uniform is visibly soiled with blood or other body fluid, change your uniform, place the soiled uniform in a plastic bag and have it laundered separately using hot water and detergent. If you have significant exposure (splashing of body fluid in the eye, mouth or open skin lesion) consult with your medical staff regarding potential follow up recommendations.

2. Is there a danger that I can take the AIDS virus home to my family on my body or on my uniform?

   There is no danger to your family if you wash your hands and change your clothing after exposure to contaminated blood or body fluids.

3. We deal with many violent and disruptive prisoners. What do we do if we get scratched or bitten by an AIDS-infected inmate?

   Avoid being bitten. If it happens, wash the wound thoroughly with soap and water as soon as possible; report the incident to your supervisor and seek medical care for treatment of the bite wound. There are no cases of AIDS reportedly transmitted through bites and scratches.

4. Do we need special equipment to do CPR?

   No transmission of the AIDS virus (or even of the more easily transmitted Hepatitis B virus) during mouth-to-mouth resuscitation (CPR) has ever been documented. If you have access to a plastic shield for mouth-to-mouth resuscitation, it is recommended that you use it; but not having a device at hand definitely should not prevent you from giving CPR. The chance that you can help someone outweighs any chance of contracting the virus.

5. Is there a danger in picking up mattresses, clothing, bedding, and food trays of AIDS-infected inmates?

   Food trays carry no risk. Clothes and linens visibly contaminated with body fluids should be placed in a plastic bag and laundered separately. Persons handling contaminated clothing or linens should wear gloves, especially if they have open wounds on the hands.

6. We often find hypodermic needles during cell searches. What if we accidentally get stuck with a contaminated needle?

   Report any needle sticks to your supervisor and consult with your medical staff regarding potential follow up recommendations. Your chances of becoming infected with the AIDS virus from a contaminated needle stick is extremely small. Only one of 1,000 health care workers who have experienced wounds from contaminated instruments has become infected with HIV after a needle stick injury. Contaminated blood was accidentally injected deep into this worker's muscle with a large bore needle.

7. What precautions should responding/arresting officers take in approaching high-risk group members or known AIDS-infected persons?

   No special precautions are necessary when approaching high-risk group members not known to be infected with a transmissible disease. When arresting someone known to be infected, gloves should be worn if there is a high likelihood of contact with blood and body fluids, particularly if the arresting officer has open skin wounds on the hands.

8. During intake procedures, (screening, body searches, fingerprinting, and photographing), what precautions should the officer take in cases of arrestees suspected or diagnosed with AIDS?

   No special precautions are needed for screening, fingerprinting and photographing. Body searches that may result in contact with blood or other body fluids should be conducted with gloved hands, particularly if the officer has broken skin on the hands.

9. What precautions should the officer in the correctional facility take during cell searches of persons diagnosed with AIDS?

   No special precautions are indicated for cell searches except for the general awareness of the possible presence of concealed sharp objects. Gloves should be worn when conducting body searches, particularly if an officer has broken skin on the hands.

10. What precautions should the correctional officer take in transporting the AIDS-infected arrestee or inmate to jail following arrest or to court for ensuing proceedings?

    No special transport precautions are necessary for an AIDS-infected inmate or arrestee unless the person is also infected with a communicable disease such as Tuberculosis which can be airborne. Consult medical authorities for any special precautions that may be appropriate for a specific inmate based on his/her medical status.

Inmate Training Materials

INTRODUCTION

Good______ , my name is______ and I am the AIDS Education Instructor for our institution. As you are aware, the subject which we will be addressing is AIDS. For the next two hours we will be talking about AIDS, and if you have any questions, or concerns which have not been addressed, I'll be answer them at the end.

To begin with, what does AIDS mean?

The term AIDS stands for **ACQUIRED IMMUNE DEFICIENCY SYNDROME**:

Acquired	means that a person was not born with the illness, but became ill from exposure to the virus.
Immune Deficiency	means that this illness attacks the body's natural disease defense system, leaving it unable to fight off infection.
Syndrome	means that people who are ill with AIDS may display/show any number of a group of symptoms; the disease is not exactly the same in each person.

Newspapers and television report new AIDS developments daily. However, **two** aspects of this disease have not changed since it was first reported in 1981:

AIDS virus is still **not spread** by casual contact; and

there is no cure or vaccine for this virus people who get AIDS die from it.

HISTORY OF AIDS

AIDS was first discovered in the United States in 1981. Scientists from the Centers for Disease Control discovered two initial risk groups:

Gay and bisexual men with multiple sexual partners; and

IV drug users who have shared needles and syringes, **"works"**.

Further study led them to add additional risk groups:

Female sexual partners of men at risk for or infected with AIDS;

Blood or plasma transfusion recipients from 1978 - April 1985; and

Infants born to parents at risk for AIDS.

Blood or sexual contact was the link among infected people.

In 1983, scientists found the cause of AIDS, a virus called HIV. HIV stands Human Immunodeficiency Virus. It is also called HTLV-III or LAV. But we will refer to it as the AIDS virus.

The current number of cases is over 35,000 with states like New York, New Jersey, California, Texas, and Florida reporting the highest incidences of AIDS. As this slide indicates, no state is unaffected by the disease and Georgia currently ranks eighth.

Show slide #1.

The next slide traces the number of AIDS cases since 1981. The numbers at the top are new cases reported each year; the numbers at the bottom reflect the cumulative, running totals, of cases. About 60% of all cases have died.

Show slide #5.

HOW THE VIRUS WORKS IN THE BODY

If the virus is able to enter the body and find its way into the bloodstream, it can have devastating effects. The virus attacks and destroys the blood cells which fight off disease and infection. This causes the body to become weak and susceptible to serious life-threatening infections.

It can take anywhere from 6 months to 9 years or more after one is infected with the virus to show symptoms. This is called the "incubation" period. However even though no symptoms are present, the person can transmit, give, the virus through their blood, semen or vaginal secretion. They are contagious, able to transmit it, throughout their life

TRANSMISSION: How the virus is transmitted

Blood, semen (cum), vaginal secretions and breast milk of an infected person have been found to be the only transmitters of the AIDS virus.

AIDS is transmitted through intimate sexual contact with an infected person, through vaginal, anal/rectal or oral sex. AIDS is also transmitted through blood to blood contact with an infected person. This happens most frequently through sharing intravenous drug needles and syringes, works. It can also occur by sharing tattoo needles, razors, toothbrushes, or any other item that may puncture the skin or allow contaminated blood into an open cut or wound. AIDS can also be transmitted from an infected mother to her unborn child.

Explain what the terms vaginal,anal, rectal, and oral sex mean.

Even after all these years of studying thousands of AIDS cases, no other methods of transmission have been found.

There is **no evidence** that AIDS is transmitted through:

Being closely associated with an infected person on a daily basis;

Shaking hands, touching, or other non-sexual physical contact with an infected person;

Using utensils, trays, sheets, towels or food that has been touched or used by an infected person;

Coming into contact with toilet seats, showers, recreational equipment, or any other facilities used by an infected person;

Being sneezed on, coughed on, or spit at by an infected person.

There is no evidence that being in prison increases the risk of developing AIDS. Nearly all of the inmates who have developed AIDS had a previous history of intravenous drug use, or shooting up, or homosexual activities. Inmates who have not engaged in homosexual activity, intravenous drug use, tattooing, or sexual activity with someone infected with the virus have no greater risk of developing AIDS than any other person.

Furthermore, no cases of AIDS have resulted from casual contact. No health care workers, such as doctors, nurses, dentists or orderlies, have contracted AIDS from routinely taking care of AIDS patients. Even where children have played, eaten, slept, kissed and fought with a brother or sister with AIDS, none have become infected. No one has ever contracted AIDS at work, even after all these years.

SYMPTOMS OF AIDS

The symptoms of AIDS are persistent and unexplained. They include:

unusual fatigue or tiredness;

rapid weight loss;

persistent fever;

drenching night sweats;

swollen lymph nodes;

chronic diarrhea;

Explain these medical conditions. Do not assume that inmates know what even the most common terms mean.

Show slides

dry cough and/or shortness of breath;

white patches inside of mouth;

unusual bruising or bleeding;

brownish, reddish, or bluish skin spots;

8,#9d,9 & 10 - examples of Thrush/Yeast Infection & Kaposis Sarcoma.

DIAGNOSIS OF AIDS

The diagnosis of AIDS must be made by a physician using laboratory tests.

WHO IS AT RISK OF AIDS?

AIDS RISK GROUPS

EVERYONE IS AT RISK according to their behavior. AIDS is **not** a disease of gay or bisexual men, but it affects children, heterosexuals, people who have had blood transfusions, IV drug abusers, black, white, Hispanic, rich and poor. **THE AIDS VIRUS DOES NOT DISCRIMINATE.**

The AIDS epidemic has occurred in particular groups of people who engage in high-risk behaviors. This slide describes the distribution of cases by risk group. The risk groups are:

Show slide #4.

Gay or bisexual men (66%)
Homosexuals who are IV Drug Users (8%)
IV Drug Users (17%)
Hemophiliacs (1%)
Heterosexuals (4%)
Transfusion Recipients (2%)
Undetermined (3%).

Show slide #7.

REMEMBER in prison, inmates who get tattooed are considered at risk.

The Undetermined group does not represent a different method of transmission. These people were either lost to "follow-up"; were uncooperative with health care investigators; or died before their case could be thoroughly investigated.

The important points to understand about AIDS risk groups are:

Risk groups are associated with high-risk behaviors;

Sexual contact with anyone who is a risk group member or has been the partner of a risk group member puts a person at risk of acquiring the infection.

THE AIDS ANTIBODY TEST

A blood test has been developed to determine whether or not a person has been exposed to the virus. All the test measures is whether or not one has been exposed to the virus, and produced antibodies:

Having a positive test could mean only one of three things:

ASYMPTOMATIC CARRIER: A person who has the virus in their body, but has no symptoms of the disease.

AIDS RELATED COMPLEX (ARC): A person who has symptoms associated with AIDS and is not able to fight off infection as well as a healthy person.

AIDS: A person who is immune suppressed, and has a life threatening infection.

SO, A POSITIVE TEST DOES NOT MEAN THAT YOU HAVE AIDS OR THAT YOU WILL BECOME ILL WITH AIDS.

A POSITIVE TEST DOES MEAN THAT YOU CAN INFECT OTHERS WITH THE VIRUS, and you must take precautions to prevent spreading the infection.

TO RECAP:

AIDS is not spread by casual contact. In order to infect someone, the virus must enter the bloodstream through either sexual contact or direct contact with infected blood. You cannot get AIDS from:

Toilet seats (the virus doesn't live long outside the body and it can't get directly into the bloodstream from a toilet seat)

Sharing eating utensils, a cup, telephones, work equipment, water fountains, doorknobs, etc.

People who sneeze, cough, cry around you. (The virus is blood borne, unlike the flu or a cold, which are airborne).

Physical contact that is not sexual contact such as hugging, shaking hands, etc. The risky behavior involves sharing blood, semen, and vaginal secretions.

AIDS is spread by sexual contact, the sharing of contaminated needles or blood products and from infected women to their infants. Therefore, to protect yourself:

Don't share items that could draw blood, such as razors, tattoo needles, IV drug needles or toothbrushes;

Do not engage in sexual activity;

Wash well with hot water and soap after coming into contact with someone else's bodily fluids. The AIDS virus is very fragile, weak, outside the body and will be killed.

Clean up spills of blood and other bodily fluids using industrial strength disinfectant, the kind in use in prison.

AFTER RELEASE OR ON LEAVE

Instructor Notes

After release or while on leave, there are further steps you can take to minimize, reduce, your risk for getting AIDS:

Know and limit your number of sexual partners;

Use condoms to avoid the exchange of bodily fluids;

Never share needles.

In closing, if you feel that you may have symptoms of ARC or AIDS you should see the medical staff. You can be assured that you will receive the best treatment possible.

Now for next 40 minutes, we will be watching a video film developed by inmates for inmates at the Taconic State Prison in New York State.

For males: Show video, "A Bad Way to Die."

After the video, we will have time to answer any questions which you may have.

For females: Show video, "Sex, Drugs & AIDS".

Curriculum for Staff and Inmates

WASHINGTON

DEPARTMENT OF CORRECTIONS

CHASE RIVELAND, SECRETARY

A
I
D
S

LESSON PLAN FOR STAFF AND OFFENDERS

OCTOBER 1987

DEPARTMENT OF CORRECTIONS

EMPLOYEE DEVELOPMENT & TRAINING

TITLE

AIDS TRAINING FOR STAFF TRAINERS

NOTES

INTRODUCTION

1. Introduction of self and assistant
2. Sign H.R.D.I.S. Form
3. Goals of training

Slide #1, 9/87

- To provide current information on the cause and symptoms and methods of transmission of the AIDS virus.
- To provide explanation of the HIV antibody test.
- To provide staff guidelines for exposure to potentially infectious materials.
- To provide an overview of the DOC Policy on AIDS.
- Reduce high risk behaviors
- To reduce on-the-job stress through reduction in misinformation and increase in knowledge.
- To save lives.

OVERVIEW

Aids is now one of the ten leading causes of death. It is projected that by 1991, the cumulative total of AIDS cases will exceed 270,000 with more than 179,000 deaths. At this time, there is no cure or vaccine; Most victims die within one to three years. But experts feel that half of these people have not been infected yet.

Slide #2, 9/87
Slide #3 and 3A, 6/87
Statewide stats

Aids is 100% preventable.

QUESTIONNAIRE - PRETEST

Explain that the training will include a pre-test and a post-test to:

1. Measure the effectiveness of the training;

DEPARTMENT OF CORRECTIONS

EMPLOYEE DEVELOPMENT & TRAINING

TITLE

AIDS TRAINING FOR STAFF TRAINERS

	NOTES:
2. Identify areas which might require further training;	
3. Provide critical information which might save lives of other correctional staff and offenders.	
We are asking for open and honest answers. This information is anonymous. You can not be identified.	Hand out questionnaires Do not Collect questionnaires
VIDEO	
Introduce video	Show video
Comments, questions, regarding video	Question/Answer
Break - 10 minutes	
WHAT IS AIDS?	
	Slide #4, 9/87
Acquired Immune Deficiency Syndrome	

Acquired:	This means it is not inherited or a genetic condition.
Immune:	The body's natural capability to protect against infection and disease.
Deficiency:	Incomplete or lacking
Syndrome:	A combination of signs and symptoms that is characteristic (or "adds up to") a particular disease.

DEPARTMENT OF CORRECTIONS

EMPLOYEE DEVELOPMENT & TRAINING

TITLE

AIDS TRAINING FOR STAFF TRAINERS

NOTES:

Slide #5, 9/87

So, AIDS is a virus that is acquired, that causes a deficiency in the body's immune system, making you unable to fight off a characteristic syndrome. The virus that causes AIDS is called Human Immunodeficiency Virus--HIV. It has been called HTLV; Human T-Lymphocytic Virus Type III; throughout the training we call it HIV.

Slide #6, 9/87

WHAT IS THE IMMUNE SYSTEM?

In order to understand the virus, you must first understand the body's immune system.

The body's immune system defends itself in several ways. One is the skin, an external protection. Another is the immune system, an internal protection.

The internal system defends us against attacks by "foreign" invaders. When working properly it fights off infections from bacteria, viruses, etc. When it is not, we are defenseless against everything from allergies to cancer. It works by identifying "antigens" or "foreigners." This triggers an immune response. Two types of cells are the primary soldiers in this response. They are both Lymphocytes. They are called B cells and T cells. B cells make antibodies. These exactly match a specific antigen. There are two types of T cells: 1) "helper" cells that turn on B cells; and 2) "suppressor" cells that turn them off. The AIDS virus affects the "helper" T cells, causing low levels of "helpers" and normal levels of "suppressor" cells. This imbalance causes a defect in the immune system, leaving the body open to infections.

RESPONSE TO THE VIRUS - Signs and Symptoms

Once an individual has been infected with HIV, most become carriers of the virus and can infect others. But, there are three possible physical responses:

DEPARTMENT OF CORRECTIONS

EMPLOYEE DEVELOPMENT & TRAINING

TITLE

AIDS TRAINING FOR STAFF TRAINERS

NOTES:

Slide #7, 9/87

1. No signs or symptoms:
   *Doesn't look or feel sick
   *May or may not become sick
   *Doesn't know he/she is infected
   *Can infect others

2. AIDS Related Complex (ARC):
   *Lymphadenopathy
   *Symptoms such as:
      Unusual fatigue or listlessness
      unexplained weight loss
      persistent fever of 100 degrees or more
      recurrent drenching night sweats
      chronic unexplained diarrhea
   *May or may not progress to AIDS; can be fatal
   *Can infect others

3. AIDS:
   *Opportunistic infections/cancers (dry cough; shortness of breath; oral thrush, brownish, reddish, bluish spots on the skin)
   *CNS deficiencies (memory loss, forgetfulness, confusion, change in coordination, delusions, slurred speech)
   *Wasting syndrome
   *Can infect others
   *Fatal

WHERE THE VIRUS IS FOUND IN THE BODY

Slide #8, 9/87

High Risk Body Fluids

BLOOD
SEMEN
VAGINAL SECRETIONS

Low Risk Body Fluids:

URINE
SALIVA
TEARS
FECES

DEPARTMENT OF CORRECTIONS

EMPLOYEE DEVELOPMENT & TRAINING

TITLE

AIDS TRAINING FOR STAFF TRAINERS

NOTES

At this time, no cases of AIDS are known to have been transmitted by urine, tears, saliva or feces. CDC has studied families of persons with AIDS. These studies have shown that family members living with persons with AIDS (sharing food, towels--even toothbrushes) have not become infected with the virus--unless they have sex with that person.

HOW HIV CAN BE TRANSMITTED

This virus is caught not by what you are, but by what you do:

Slide #9, 9/87

*Unprotected sex with multiple partners
*Present or past IV drug use
*Received blood or blood clotting products prior to screening
*Injection of contaminated blood, through needle sticks or tattooing.
*Unprotected sex with any of the above (male or female)
*Infection to fetus during child birth

HOW HIV CAN NOT BE TRANSMITTED

Slide #10, 9/87

Casual contact:

* Sharing the same bathroom
* Eating food prepared by an infected person
* Sharing linen
* Touching, hugging, shaking hands
* Coughing, sneezing, spitting
* Sweat
* Dry kisses
* Using the same utensils
* Mosquitoes

DEPARTMENT OF CORRECTIONS
EMPLOYEE DEVELOPMENT & TRAINING

TITLE

AIDS TRAINING FOR STAFF TRAINERS

NOTES:

HIGH RISK BEHAVIOR

Slide #11, 9/87

You are considered to be at high risk for exposure to HIV if you:

- Had/have sex with one or more homosexual/bisexual men
- Had/have sex with a prostitute
- Use/used nonsterile needles or "works"
- Had/have sex with an infected person (i.e., person who received transfusion of infected donor)
- Had/have multiple partners (male or female)
- Had/have unprotected sex with any of the above

SAFE BEHAVIOR

Slide #12

You are considered to be at low risk for exposure to the HIV if you:

- And your sexual partner have been sexually exclusive (no other partner) for at least ten years.
- Have never used I.V. street drugs.

HIV ANTIBODY TEST

Slide #13

- There is no test for AIDS or the AIDS virus (HIV)
- The only test available is for antibodies:
  - ELIZA
  - Western Blot
- It can take three weeks to a year after exposure to the virus to develop the antibodies

- The HIV antibody test is not a test for AIDS, and a positive antibody test is not a diagnosis of AIDS.

TITLE

AIDS TRAINING FOR STAFF TRAINERS

NOTES:

Slide #14

Positive test means:

- Exposed to HIV
- May be Infectious to others
- May or may not become ill
- Should not donate blood, sperm, tissues, organs

Negative test means:

- May be infected, but hasn't made antibodies yet
- May be infected, but will never make antibodies
- May not be infected
- Should not donate blood, sperm, tissues, organs if in a high risk group

YOU CAN HAVE A NEGATIVE TEST AND STILL DIE OF AIDS.

DOC POLICY

Briefly review policy content

Hand out policy

DOC STAFF GUIDELINES

OMIT THIS SECTION FOR OFFENDER TRAINING

See Last Page of Handout.

TAKE REASONABLE PRECAUTIONS

It is critical that people realize that all persons should be considered potential carriers:

Slide 15

- Do you know if your sex partner has been infected by the virus? They may not know. Remember, you are having sex not only with your partner, but everyone they have had sex with. USE CONDOMS for all sexual activities--vaginal, oral, anal.

DEPARTMENT OF CORRECTIONS

EMPLOYEE DEVELOPMENT & TRAINING

TITLE

AIDS TRAINING FOR STAFF TRAINERS

NOTES:

Positive test means:

Slide #14

- Exposed to HIV
- May be Infectious to others
- May or may not become ill
- Should not donate blood, sperm, tissues, organs

Negative test means:

- May be infected, but hasn't made antibodies yet
- May be infected, but will never make antibodies
- May not be infected
- Should not donate blood, sperm, tissues, organs if in a high risk group

YOU CAN HAVE A NEGATIVE TEST AND STILL DIE OF AIDS.

DOC POLICY

Briefly review policy content

Hand out policy

TAKE REASONABLE PRECAUTIONS

It is critical that people realize that all persons should be considered potential carriers:

Slide 15

- Do you know if your sex partner has been infected by the virus? They may not know. Remember, you are having sex not only with your partner, but everyone they have had sex with. USE CONDOMS for all sexual activities--vaginal, oral, anal.

- Advise women to use a birth control method containing Nonoxynol 9 Spermicide. It is in several types of foam and suppositories.

- Never share "works." If you are an IV street drug user--even the "recreational" user--clean out your works:

  Boil works for 15 minutes or

  Put two tablespoons liquid bleach into a glass of water, flush the solution through the works three times. Take apart the works and soak it for 15 minutes. Rinse well with plain water. Reassemble and flush with plain water three times.

- Avoid tattoos

Remember all persons, whether staff or offenders, should be considered potentially infectious.

QUESTIONNAIRE - POST TEST

CLOSURE

Handout:

Collect Questionnaire

Distribute Handout

Our primary goal in providing this training has been to save lives by educating you about this disease and how to avoid exposure to it. But, the rest is up to you. Therefore, we are providing the material for your own use.

Remember:

> All persons should be considered potentially infectious, and **AIDS doesn't care what or who you are, but what you do.**

STAFF GUIDELINES

STAFF GUIDELINES (A)

Blood to blood contact through break in skin

1. Allow wound to bleed freely

   EXCEPTION: Arterial bleed where excessive loss of blood would be harmful
2. Report to Health Services
3. Assure that wound is cleansed thoroughly
4. Follow-up with personal health care provider for:
   - a) Wound follow-up
   - b) Necessary vaccines, i.e., tetanus
   - c) Counseling regarding HIV testing

STAFF GUIDELINE (B)

Mucous Membrane Exposure

1. Report to Health Services
2. Flush mucous membranes with:
   - a) Eyes: copious amounts of normal saline or tap water
   - b) Mouth: rinse mouth with hydrogen peroxide mixed 50/50 with water. Spit solution out.
3. Follow-up with personal health care provider for counseling regarding HIV testing.

STAFF GUIDELINE (C)

Contaminated Clothing

1. Wash hands
2. obtain clean clothing from uniform issue
3. Obtain dissolvable laundry bag from uniform issue
4. Remove clothing and place in dissolvable bag and secure bag
5. Shower/shampoo with hand soap and shampoo (any type or brand)
6. Dress in clean clothing
7. Send clothing to laundry (in dissolvable bag)

Posters

THE ULTIMATE POINT

Contact Your Medical Office For Information

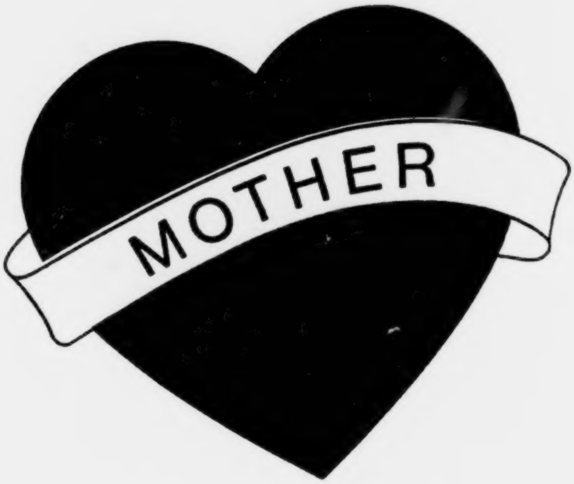
SHOOTING UP
AND
SHARING NEEDLES
PUTS YOU AT RISK
FOR AIDS.

THIS FACT MAY SAVE YOUR LIFE!

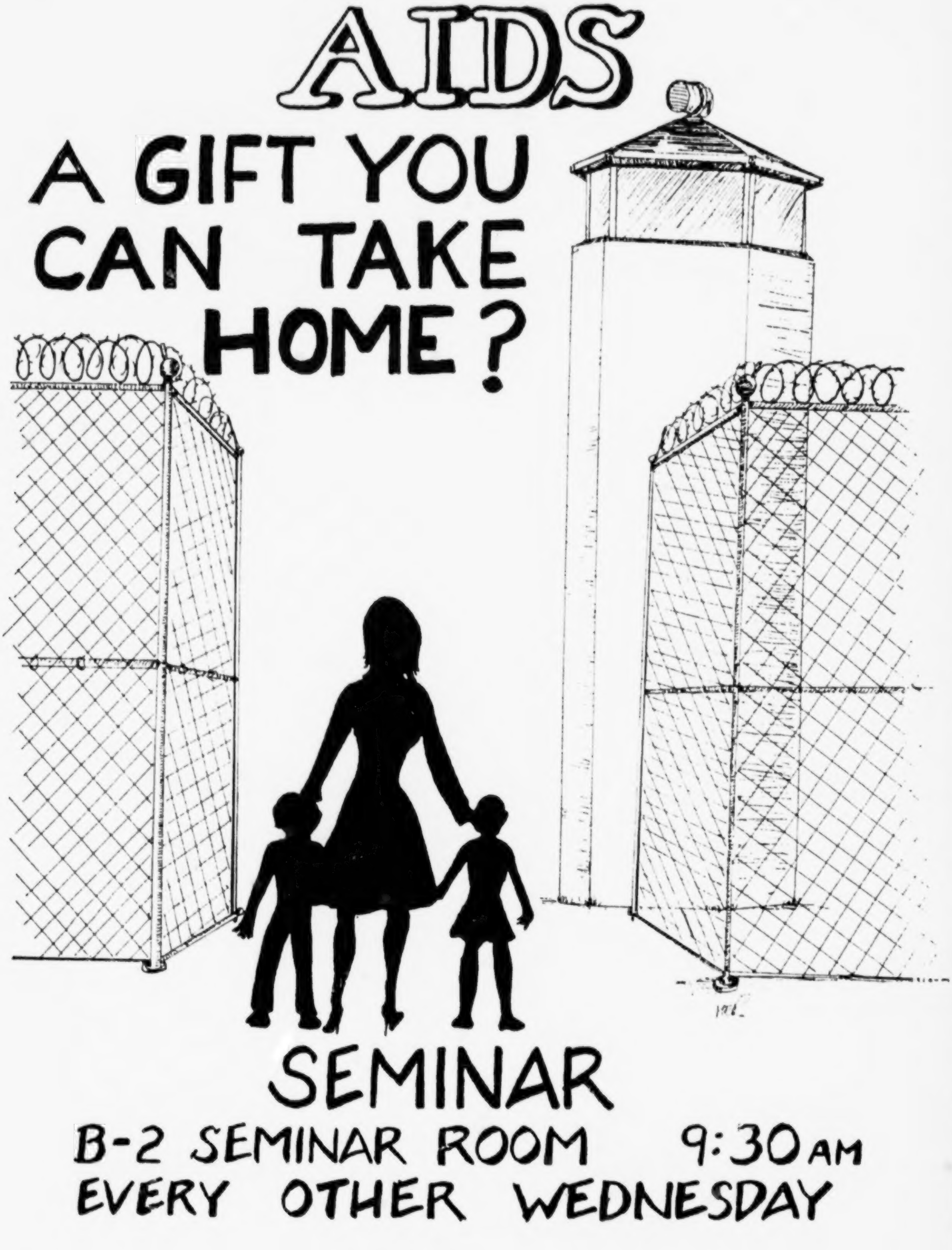
CALIFORNIA DEPARTMENT OF CORRECTIONS OFFICE OF HEALTH CARE SERVICES MAY 1987

AIDS

PREVENTION



DON'T SHARE TATTOO KITS



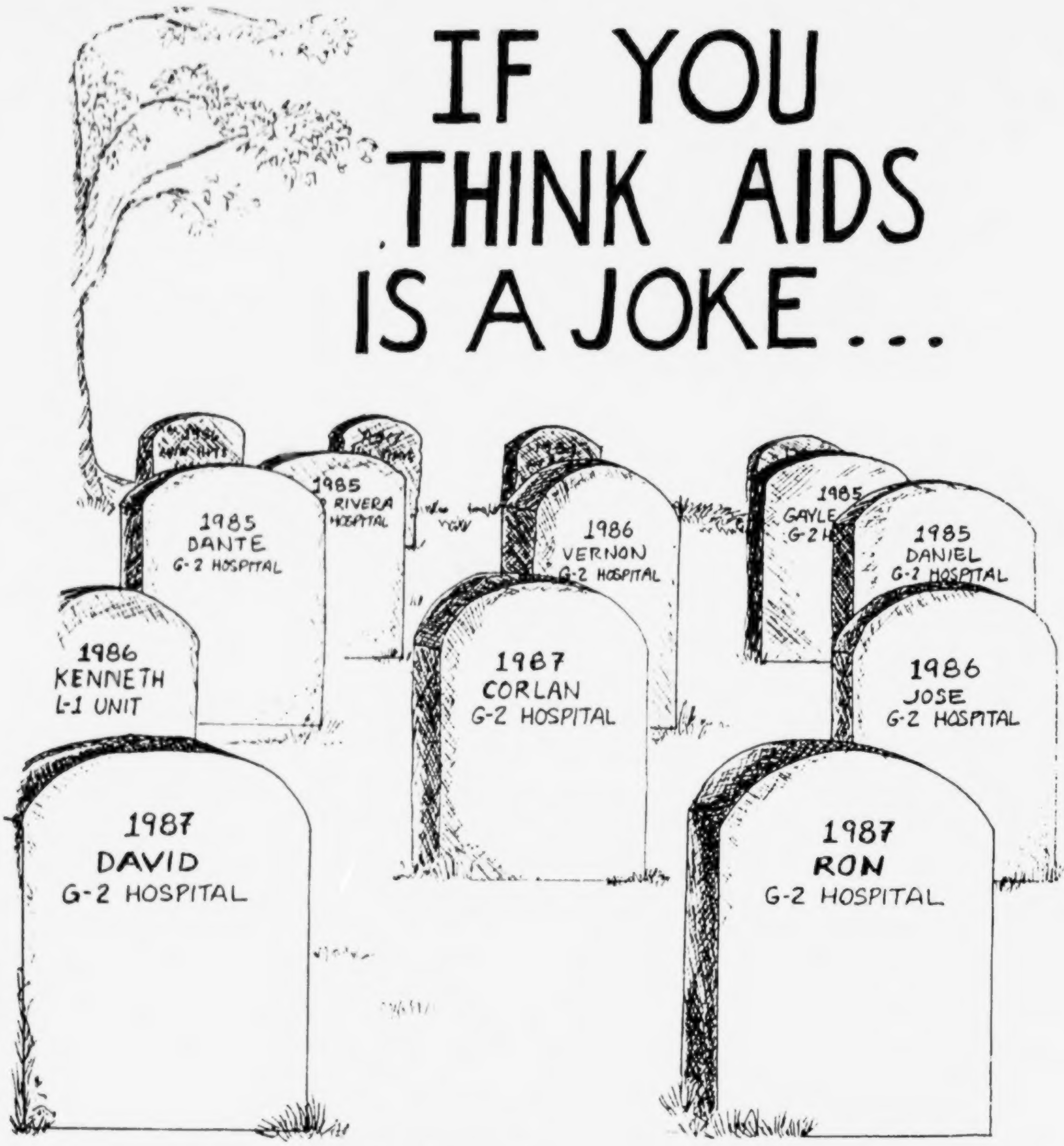
AIDS

A GIFT YOU CAN TAKE HOME?

SEMINAR

B-2 SEMINAR ROOM 9:30 AM
EVERY OTHER WEDNESDAY

IF YOU THINK AIDS IS A JOKE...


1985
DANTE
G-2 HOSPITAL
1985
RIVERA
HOSPITAL
1986
VERNON
G-2 HOSPITAL
1985
GAYLE
G-2 H
1985
DANIEL
G-2 HOSPITAL
1986
KENNETH
L-1 UNIT
1987
CORLAN
G-2 HOSPITAL
1986
JOSE
G-2 HOSPITAL
1987
DAVID
G-2 HOSPITAL
1987
RON
G-2 HOSPITAL

ASK THEM ... OR US

SEMINAR 9:30 AM
EVERY OTHER WEDNESDAY
B-2 SEMINAR ROOM

Counseling Materials

DC 476
NEW 5/87

NORTH CAROLINA DEPARTMENT OF CORRECTION

DIVISION OF PRISONS

Verification of Counseling of People with Seropositive HIV Antibody Test Results

Inmate Name ____________________ Inmate Number ____________________

Location ____________________ Unit Number ____________________

Initial Counseling Date ____________ Exit Counseling Date ____________
(Recounsel within 30 days of release)

Check as Completed:

Initial Counseling	Exit Counseling	
______	______	1. Inmate given copy of "What Every Inmate Should Know About AIDS.
______	______	2. Inmate given copy of "Information For Persons With A Positive HIV Antibody Test Result".
______	______	3. High risk individuals be advised:
______	______	a. of early clinical manifestations of HIV infection, AIDS and AIDS related conditions.
______	______	b. that the prognosis for an individual infected with HIV over the long term is not known. However, available studies indicate that most persons will remain infected, but asymptomatic.
______	______	c. to seek medical evaluation as indicated for an individual who develops signs or symptoms suggestive of HIV infection, AIDS, or AIDS related conditions.
______	______	d. that although the person may be asymptomatic, there is a risk of infecting others by sex and sharing needles.
______	______	e. that blood, plasma, body organs, other tissues, or sperm should not be donated.
______	______	f. that children born since 1979 to women with a positive HIV test should be clinically evaluated.

______ ______ g. women (or women who have a high risk sexual partner) who have a positive HIV test, should be advised that they are at increased risk of acquiring AIDS and that any offspring is at an increased risk for acquiring AIDS.

______ ______ h. that tooth brushes, razors or other implements that could be contaminated with blood should not be shared.

______ ______ i. that in the absence of intimate contact, "contacts" need not be referred.

______ ______ j. that after accidents resulting in bleeding, contaminated surfaces should be cleaned with household bleach freshly diluted 1:10 in water (custody and nursing staff have been advised of this).

______ ______ k. that the devices that puncture the skin such as drug injecting needles, tattoo needles and ear-piercing needles should not be used or shared.

______ ______ l. that when seeking medical or dental care for illnesses inmates should inform those responsible for their care of the positive HIV results so that appropriate evaluation can be undertaken and precautions taken to prevent transmission to others.

______ ______ m. that most persons with positive HIV test results need not consider a change in employment. However, those persons whose work involves significant potential of exposing others to his/her blood or other body fluids should, at a minimum, be advised to act prudently and take precautions such as wearing gloves.

______ ______ n. that when inmates are to be employed or plan to be employed in medical or dental or other health care professions upon discharge from prison they should be advised that when performing invasive procedures or if they have skin Lesions to take precautions similar to hepatitis B - to protect their patients from the risk of infection.

______ ______ o. that a sexual or needle sharing partner of a person with a positive test should be advised to seek clinical evaluation if they develop symptoms and be advised to seek information about HIV infection.

______ ______ 4. I have fully explained to the inmate the significance of the HIV antibody test result and have recommended appropriate changes in behavior.

______ ______ 5. I hereby certify that I have counseled

____
(Inmate's Name)
and that I have answered any questions to the best of my ability. I believe the inmate understands the answers and explanations I have given.

Initial Counseling ______________________________ __________
Signature and Title Date

Exit Counseling ______________________________ __________
Signature and Title Date

File in Section II Out-Patient Health Record

Counseling Materials
Office of Health Status Monitoring
State of Oregon

April 1987

INFORMATION FOR THE HIGH RISK PERSON WHO HAS A NEGATIVE HIV ANTIBODY TEST

What is AIDS?

Acquired immunodeficiency syndrome (AIDS) is a serious illness resulting from failure of an important part of the immune system. This immune failure is due to infection of the lymphocytes (a type of white blood cell) by a virus known as human immunodeficiency virus (HIV).

Persons with HIV infection develop life-threatening infections or certain cancers, including Kaposi's sarcoma. Many persons infected with HIV may develop an illness known as AIDS-Related Complex, and some may develop no illness at all. Much is still unknown about the long-term effects of HIV infection.

If illness does occur, symptoms may include significant unexplained weight loss, persistent swelling of lymph nodes, unexplained fever lasting for several weeks, unexplained diarrhea lasting for weeks, recurrent yeast infections in the mouth, and recurring episodes of unexplained sweating during the night.

How is the Virus Spread?

The virus is spread from an infected person to others by sexual contact, by blood or blood products, or by sharing needles used for injecting drugs.

A woman infected with the virus can give it to her unborn or newborn child. It is not known whether spread from mother to child occurs before the child is born, at the time of birth, or during the first few days or weeks after birth. It is possible that spread could occur at all these times.

It may be possible that an infected person can expose others through saliva during oral-genital contact or with kissing involving the exchange of saliva, although this has never been shown to happen.

What Does a Negative Test Mean?

If one of the following descriptions applies to you, your negative test result may not necessarily mean that you have not been exposed to the virus that causes AIDS. This is because it is not yet known how frequently persons who are well, yet infected with the virus, may have a "false negative" rest. A "false negative" test means that the test does not detect antibody against the HIV virus, even though the person has been infected. This can happen because of technical problems in the laboratory, or because a person's immune system may not develop antibody against the virus until some time after infection. At present, it is believed that a person will develop antibodies within 12 weeks of becoming infected.

The risk group descriptions are:

1. Male who has sexual contact with another man since 1977
2. User of intravenous drugs
3. Hemophiliac
4. Person with multiple heterosexual contacts, especially prostitutes
5. Sexual partner of a person with HIV infection or a person at increased risk of exposure to HIV (i.e., one of the above)

Additionally, if you continue to have one of the above risk factors, a negative antibody test does not protect you from risk of exposure in the future.

Therefore, even though you have had a negative HIV antibody test, you should follow these suggestions at all times in the future:

1. Refrain from donating blood or plasma, sperm for artificial insemination, and body organs or tissues for transplantation.
2. Avoid exposing others through sexual contact. You can do this by using safer sex practices or by abstinence. Ask your counselor for more information.
3. Avoid sharing of needles for injecting drugs.
4. If you are a woman of childbearing age, you should not consider pregnancy until more is known about the risk of transmission of infection from a mother to her newborn infant.
5. Avoid sharing toothbrushes, razors, or other implements that could become contaminated with blood.
6. Avoid risk of being exposed to HIV by limiting your sexual partners, using safer sexual practices, and avoiding sexual contact with persons known to be HIV positive.

For further information about "safer sexual practices" please talk with your counselor now.

Office of Health Status Monitoring
P.O. Box 231
Portland, OR 97207; Phone 229-5792

State of Oregon April 1987

INFORMATION FOR THE PERSON WHO HAS HAD A REACTIVE HIV ANTIBODY TEST

What Does a Reactive Test Mean?

Your test result was "reactive". This means that the blood specimen you submitted showed evidence of the presence of HIV antibody on three separate ELISA tests, along with a postive result on the IFA test. This almost certainly means that you have been infected with HIV. It probably means that you are still carrying the virus and can infect others through sexual contact, sharing needles, or donating blood, plasma, sperm, or tissues or organs.

Your positive test result does not necessarily mean that you will develop AIDS.

There is a very small chance that your test results could be falsely positive. If this is the case, you may never have been exposed to HIV, but may have had a positive result because the test cross-reacted with something else in your blood, or because of a technical problem in the laboratory.

What is AIDS?

Acquired immunodeficiency syndrome (AIDS) is a serious illness resulting from failure of an important part of the immune system. This immune failure is due to infection of the lymphocyte (a type of white blood cell) by a virus known as human immunodeficiency virus (HIV).

Persons with HIV infections may develop life-threatening infections or certain cancers, including Kaposi's sarcoma. Many persons infected with HIV may develop an illness known as AIDS-Related Complex, and some may develop no illness at all. Much is still unknown about the long-term effects of HIV infection.

If illness does occur, symptoms may include significant unexplained weight loss, persistent swelling of lymph nodes, unexplained fever lasting for several weeks, unexplained diarrhea lasting for weeks, recurrent yeast infections in the mouth, and recurring episodes of unexplained sweating during the night.

How is the Virus Spread?

The virus is spread from an infected person to others by sexual contact, by blood or blood products, or by sharing needles used for injecting drugs.

A woman infected with the virus can give it to her unborn or newborn child. It is not known whether spread from mother to child occurs before the child is born, at the time of birth, or during the first few days or weeks after birth. It is possible that spread could occur at all these times.

It may be possible that an infected person can expose others through saliva during oral-genital contact or with kissing involving the exchange of saliva, although this has never been shown to happen.

What Should You Do because of Your Positive Antibody Test?

1. You should ask to submit another blood specimen for testing, just to be sure that a technical problem in the laboratory did not cause your first specimen to be falsely positive.

2. You should see a doctor for an examination. Be sure to choose a doctor with whom you can form a comfortable relationship for follow-up examinations. If you do not have a regular doctor, ask the person who gave you this form to suggest a list of names from which you can choose.

3, If your doctor finds no evidence of AIDS-related illness by examination, you should plan to visit him or her for re-evaluation at least twice a year. If significant, unexplained weight loss, unexplained fever, unexplained diarrhea, yeast infections in your mouth, persistent lymph node swelling, or severe sweating during the night occur between your routine doctor visits, you should seek medical care right away.

4. If your doctor does find evidence of AIDS-related illness by examination, you should follow his or her advice for further evaluation.

5. You should understand that you will probably remain infected with this virus indefinitely. This means that you may spread this infection to others, even if you remain well. To avoid exposing others you should:

a. Refrain from donating blood or plasma, sperm for artificial insemination, and body organs or tissues for transplantation.

b. Avoid exposing others through sexual contact. You can do this by using safer sex practices or by abstinence. Ask your counselor for more information.

INFORMATION FOR "REACTIVE" HIV ANTIBODY TEST RECIPIENTS (con't.)

c. Avoid sharing of needles for injecting drugs.

d. If you are a woman of childbearing age, you should not consider pregnancy until more is known about the risk of transmission of infection from a mother to her newborn infant.

e. Avoid sharing toothbrushes, razors, or other implements that could become contaminated with blood.

f. If you bleed from a cut or other wound, you should clean soiled clothes, furniture, or other surfaces with a mixture of household bleach and water (1 part bleach mixed with 100 parts water).

g. You should inform any person providing you with medical or dental care of your positive antibody test. This will enable your health care providers to take appropriate precautions to avoid exposure of others.

h. If your work involves significant potential for exposing others to your blood or other body fluids you should discuss with your doctor precautions you should take to prevent such exposures.

6. You should inform your past sexual partners of your test result with encouragement to see a doctor or the health department for evaluation.

7. You should inform your needle-sharing partners of your test result with encouragement to see a doctor or the health department for evaluation.

8. If you are a woman, and you have any children who were born since 1977, you should take them to a doctor for evaluation.

9. If you are pregnant, or if your sexual partner is pregnant, you should seek medical advice. Remember that a woman with HIV infection may transmit AIDS to her unborn child or newborn child.

What Changes in Your Daily Activities Do You Not Need to Make?

You do not need to change your lifestyle beyond the suggestions listed above. Specifically:

1. You can continue your usual social contact with family and friends. Hugging and kissing on the cheek do not spread the virus.

2. You can continue your usual contact with people in the community without special precautions or restrictions.

3. Unless your job involves signficant potential for exposing others to your blood or other body fluids, you can continue your usual work without special precautions.

What Should You Do if You Have Further Questions or Need More Help in Coping with the Fact that You Have a Positive HIV Antibody Test?

You should contact your doctor or county health department for help and for referral to additional sources for help.

Office of Health Status Monitoring
P. O. Box 231
Portland, OR 97207
229-5792

If Your Test for Antibody to the AIDS Virus Is Positive...

American Red Cross

U.S. Public Health Service

The virus* that causes AIDS (acquired immune deficiency syndrome) may have infected as many as 1 to 1½ million Americans.

Many people who are infected with the virus have not developed any symptoms, while others have had relatively minor illnesses. The most serious form of illness caused by the virus is AIDS, which involves loss of the body's natural immune defenses against disease.

The AIDS virus is primarily spread by sexual contact and by sharing of contaminated needles and syringes among users of intravenous drugs. The virus can also be transmitted from infected mothers to their babies during pregnancy, at birth, or shortly after birth (probably through breast milk). In a small number of cases, the virus has been spread through blood transfusions and through blood products used to treat patients with hemophilia and other blood clotting disorders.

The AIDS Antibody Test

Antibodies are substances produced in the blood to fight disease organisms. When antibodies to a specific organism are found in a person's blood, they indicate that the person has been infected by that particular organism.

Since spring 1985, a test for antibody to the AIDS virus has been used by blood collection centers to keep donated blood and plasma that might carry the virus from becoming part of the nation's blood supply. The antibody test is also available—through private physicians and at clinics in most states—to people who may want to know their antibody status. Those considered to be at risk of infection include men who have had sex with another man since 1977; people who inject illegal drugs, or who have done so in the past; people with symptoms that suggest AIDS virus infection; people from Haiti and Central African

---

***The virus that causes AIDS and related disorders has several different names: HTLV-III, LAV, ARV, and most recently HIV In this brochure it is called "the AIDS virus."**

countries, where heterosexual transmission seems to be more common than in this country; male or female prostitutes and their sex partners; sex partners of persons who are infected or are at increased risk of infection; people with hemophilia who have been treated with clotting factor products; and infants of high-risk or infected mothers.

What Does a Positive Antibody Test Mean?

If your test for AIDS antibody is positive, it usually means that you have been infected by the virus. Occasionally, however, a person may have a positive test result even though he or she has never been exposed to the AIDS virus. This is called a "false positive" reaction. To be sure that the test result is truly positive, the test is repeated, and in some cases a different type of laboratory test may also be performed.

A positive test result *does not* mean that you will get AIDS—many people with a positive test either remain free of symptoms or develop less serious illnesses. The antibody test cannot tell you whether you will eventually develop signs of illness related to AIDS virus infection—or, if you do, how serious that illness might be.

A positive test result *does* indicate that you have been infected by the AIDS virus and most probably can transmit it to others, *even if you show no symptoms.* It's likely that you will carry the virus in your body throughout your life.

How Can I Protect My Health?

After getting the results of your test, you should see a doctor for a checkup and follow-up care. Your doctor will want to discuss your situation with you thoroughly, answer your questions, make sure that you receive the counseling you need, and check you at regular intervals to help you maintain your health.

How Can I Protect Others?

To protect others from getting the virus from you, there are some important steps you should take:

- Be sure to tell your sex partners about your positive test result. Avoiding sex would eliminate any risk of spreading the virus by sexual means; however, if you and your partner decide to go ahead, be careful to protect him or her from contact with your body fluids, which may carry the AIDS virus. ("Body fluids" includes blood, semen, urine, feces, saliva, and vaginal secretions.) *Use a condom,* which will help reduce the chances of spreading the virus, and avoid practices, such as anal intercourse, that may injure body tissues and make it easier for the virus to enter the bloodstream. Oral-genital contact should also be avoided, as should open-mouthed, intimate kissing.
- People who have been your sex partners may have been exposed to the AIDS virus. If you have used intravenous drugs, anyone you have shared needles and syringes with may have been exposed too. You should tell these persons about your positive test result and urge them to seek counseling and antibody testing from a doctor or health clinic.
- Don't share toothbrushes, razors, tweezers, or other items that could become contaminated with blood.
- If you use drugs, consider enrolling in a drug treatment program to help protect your health. Remember that needles and other drug equipment must *never* be shared.
- Don't donate blood or plasma, body organs, other body tissue, or sperm.
- Clean spills of blood or other body fluids on household or other surfaces with freshly diluted household bleach—one part bleach to 10 parts water. (Don't use bleach on wounds.)
- When you seek medical help, tell the doctor, dentist, eye doctor, or other health worker who gives you care about your positive AIDS antibody test, so that steps can be taken to protect you and others.

- If you are a woman with a positive test result, consider avoiding pregnancy until more is known about the risks of transmitting the AIDS virus to your baby. If you do become pregnant, it's important to see a doctor for regular care during your pregnancy. Because the AIDS virus has been found in breast milk, you should not breastfeed your baby.

What About the Ordinary Activities of My Daily Life?

You should be careful to follow the normal practices everyone needs to maintain good health: Eat a well-balanced diet, exercise, rest, and try to manage your life in a way that avoids undue stress. But there's no reason to change your activities in ways beyond those that have already been discussed.

Your positive test status should not affect your contacts with people at work or in social situations. Special precautions are not necessary: The AIDS virus is not spread by ordinary nonsexual contact such as shaking hands, sharing an office, coughing or sneezing, preparing or serving food, or sharing toilet facilities.

Your relationships with family members and friends should continue to be close and supportive. Hugging, kissing on the cheek, and other forms of affectionate behavior that don't involve exchange of body fluids do not spread the AIDS virus.

It should be stressed that scientists have not found a single instance in which the AIDS virus has been transmitted through ordinary nonsexual contact in a family, work, or social setting.

A Final Word . . .

The news that you have had a positive result on your AIDS antibody test is not easy to receive. For your follow-up care, it's best to establish a close relationship with a doctor you trust, so that you can speak openly about your feelings, problems, and any fears you may have. Above all, ask questions—and seek assurance from any health professional who takes care of you that all information related to your health will be kept in the strictest confidence.

The U.S. Public Health Service has made AIDS and other AIDS virus-related illnesses its number one priority. Scientists all over the country are working to find ways to eliminate the AIDS virus as a threat to health. A great deal of research progress has been made—and made quickly—and there is every reason to expect these advances to continue at an even faster pace.

More information about AIDS and AIDS-related illnesses can be obtained from—

- Your doctor.
- Your state or local health department.
- The Public Health Service's toll-free hotline: 1-800-342-AIDS.
- Your local chapter of the American Red Cross.

If you would like information about drug treatment programs, call the toll-free hotline of the National Institute on Drug Abuse: 1-800-662-HELP.

Pre/Post of AIDS Knowledge

WASHINGTON
DEPARTMENT OF CORRECTIONS

AIDS TRAINING

STAFF QUESTIONNAIRE
PRE-TEST

This is an anonymous and confidential test of your knowledge and feelings about *AIDS*. Your honest answers will assist in identifying further training needs.

PLEASE ***CIRCLE*** YOUR ANSWERS ON THIS SHEET

DO NOT WRITE YOUR NAME ANYWHERE ON THIS SHEET

1. AGE (between the ages of)
   (1) 18-21 (2) 22-25 (3) 26-30 (4) 31-35 (5) 36-40 (6) 41-49 (7) 50 and up ________

2. SEX - (1) Male (2) Female ________

3. WHAT IS YOUR MARITAL STATUS?
   (1) Single (2) Cohabit (3) Currently Married (4) Widowed, Divorced ________

4. PLEASE CIRCLE THE HIGHEST COMPLETED LEVEL OF EDUCATION
   (1) Elementary (2) High School (3) College (4) Post Graduate ________

5. DO YOU HAVE CHILDREN LIVING AT HOME IN SCHOOL? (1) Yes (2) No ________

6. WHAT IS YOUR CURRENT POSITION?
   (1) Health Care Staff (2) Correctional Officer (3) Correctional Supervisor / Manager ________
   (4) Community Corrections Officer (5) Community Corrections Supervisor (6) Support Staff

7. DO YOU KNOW SOMEONE WITH *AIDS*? (1) Yes (2) No ________

8. HOW OFTEN DO YOU THINK ABOUT THE POSSIBILITY OF GETTING ***AIDS***?
   (1) Several times a day (2) Daily (3) Several times a week (4) Weekly (5) Monthly or less ________

In the following questions, please circle the answer that best matches your feelings

9 Would you feel comfortable taking care of an inmate with ***AIDS***?

(1) Yes (2) No

Why? ______________________________ ______

10 If you had a choice, would you (Check ONE answer only)

(1) Prefer to avoid inmates presenting with ***AIDS*** symptoms

(2) Choose to work with people with ***AIDS*** symptoms in preference to most other types of inmates

(3) Regard inmates with ***AIDS*** symptoms as you would any other inmate. ______

11. Do you feel you have sufficient knowledge to protect yourself from acquiring ***AIDS***?

(1) Yes (2) No ______

12. How likely do you think it is that you will get ***AIDS***?

(1) Very Likely (2) Likely (3) Not very likely (4) Will not happen ______

13. If handling blood or body fluids, gloves are: (Check **ONE** answer only)

(1) Necessary to protect the corrections worker

(2) Necessary to protect the patient with ***AIDS***

(3) Necessary to protect both patient **and** worker

(4) Not necessary ______

14. A positive test for ***HIV*** antibody means that: (Check **ONE** answer only)

(1) The person has been exposed to ***AIDS***

(2) A person will definately develop ***AIDS***

(3) A person has ***AIDS***

(4) A person is immune to ***AIDS*** ______

Page 2

Please answer "Yes" or "No" to the following statements:

	Yes	No
15. People can get *AIDS* from:		
A. Being sneezed, coughed upon	______	______
B. Touching possessions in cells of positive inmates	______	______
C. Cleaning vomit	______	______
D. Shaking hands	______	______
E. Sharing coffee cups	______	______
F. Toilet seats	______	______
G. Having feces and urine thrown at you	______	______
H. Direct contact with *AIDS* blood	______	______
I. Mosquito bites	______	______
J. Doorknobs	______	______
K. Inmate laundry	______	______
L. Mouth to mouth CPR	______	______
M. Being in the same room	______	______
N. Being stuck by a needle which was used on a person with *AIDS*	______	______
O. Sex partners of infected people	______	______
P. Infected food handlers	______	______
Q. Having sex with prostitutes	______	______
R. Other ____	______	______

STOP HERE. DO NOT TURN THE PAGE UNTIL DIRECTED TO DO SO.

APPENDIX E

CDC Guidelines

- *Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS*
- *Recommendations for Prevention of HIV Transmission in Health-Care Settings*

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

August 14, 1987 / Vol. 36 / No. 31

508 PHS Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS
515 Polymer-Fume Fever Associated with Cigarette Smoking and the Use of Tetrafluoroethylene – Mississippi
522 Update: AIDS – United States
526 Publication of Revised Case Definition for AIDS Surveillance
528 Regional Scientific Meeting of IEA, ICEN, and FETPs – January 24-29, 1988, Pattaya, Thailand

***Perspectives** in Disease Prevention and Health Promotion*

Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS

These guidelines are the outgrowth of the 1986 recommendations published in the *MMWR* (*1*); the report on the February 24-25, 1987, Conference on Counseling and Testing (*2*); and a series of meetings with representatives from the Association of State and Territorial Health Officials, the Association of State and Territorial Public Health Laboratory Directors, the Council of State and Territorial Epidemiologists, the National Association of County Health Officials, the United States Conference of Local Health Officers, and the National Association of State Alcohol and Drug Abuse Directors.

Human immunodeficiency virus (HIV), the causative agent of acquired immunodeficiency syndrome (AIDS) and related clinical manifestations, has been shown to be spread by sexual contact; by parenteral exposure to blood (most often through intravenous [IV] drug abuse) and, rarely, by other exposures to blood; and from an infected woman to her fetus or infant.

Persons exposed to HIV usually develop detectable levels of antibody against the virus within 6-12 weeks of infection. The presence of antibody indicates current infection, though many infected persons may have minimal or no clinical evidence of disease for years. Counseling and testing persons who are infected or at risk for acquiring HIV infection is an important component of prevention strategy (*1*). Most of the estimated 1.0 to 1.5 million infected persons in the United States are unaware that they are infected with HIV. The primary public health purposes of counseling and testing are to help uninfected individuals initiate and sustain behavioral changes that reduce their risk of becoming infected and to assist infected individuals in avoiding infecting others.

Along with the potential personal, medical, and public health benefits of testing for HIV antibody, public health agencies must be concerned about actions that will discourage the use of counseling and testing facilities, most notably the unauthorized disclosure of personal information and the possibility of inappropriate discrimination.

Priorities for public health counseling and testing should be based upon providing ready access to persons who are most likely to be infected or who practice high-risk behaviors, thereby helping to reduce further spread of infection. There are other considerations for determining testing priorities, including the likely effectiveness of preventing the spread of infection among persons who would not otherwise realize that they are at risk. Knowledge of the prevalence of HIV infection in different populations is useful in determining the most efficient and effective locations providing such services. For example, programs that offer counseling and testing to homosexual men, IV-drug abusers, persons with hemophilia, sexual and/or needle-sharing partners of these persons, and patients of sexually transmitted disease clinics may be most effective since persons in these groups are at high risk for infection. After counseling and testing are effectively implemented in settings of high and moderate prevalence, consideration should be given to establishing programs in settings of lower prevalence.

Interpretation of HIV-Antibody Test Results

A test for HIV antibody is considered positive when a sequence of tests, starting with a repeatedly reactive enzyme immunoassay (EIA) and including an additional, more specific assay, such as a Western blot, are consistently reactive.

The *sensitivity* of the currently licensed EIA tests is 99% or greater when performed under optimal laboratory conditions. Given this performance, the probability of a false-negative test result is remote, except during the first weeks after infection, before antibody is detectable.

The *specificity* of the currently licensed EIA tests is approximately 99% when repeatedly reactive tests are considered. Repeat testing of specimens initially reactive by EIA is required to reduce the likelihood of false-positive test results due to laboratory error. To further increase the specificity of the testing process, laboratories must use a supplemental test—most often the Western blot test—to validate repeatedly reactive EIA results. The sensitivity of the licensed Western blot test is comparable to that of the EIA, and it is highly specific when strict criteria are used for interpretation. Under ideal circumstances, the probability that a testing sequence will be falsely positive in a population with a low rate of infection ranges from less than 1 in 100,000 (Minnesota Department of Health, unpublished data) to an estimated 5 in 100,000 (*3,4*). Laboratories using different Western blot reagents or other tests or using less stringent interpretive criteria may experience higher rates of false-positive results.

Laboratories should carefully guard against human errors, which are likely to be the most common source of false-positive test results. All laboratories should anticipate the need for assuring quality performance of tests for HIV antibody by training personnel, establishing quality controls, and participating in performance evaluation systems. Health department laboratories should facilitate the quality assurance of the performance of laboratories in their jurisdiction.

Guidelines for Counseling and Testing for HIV Antibody

These guidelines are based on public health considerations for HIV testing, including the principles of counseling before and after testing, confidentiality of personal information, and the understanding that a person may decline to be tested without being denied health care or other services, except where testing is required by law (*5*). Counseling before testing may not be practical when screening for HIV antibody is required. This is true for donors of blood, organs, and tissue; prisoners; and immigrants for whom testing is a Federal requirement as well as for persons admitted to state correctional institutions in states that require testing. When there is no counseling before testing, persons should be informed that testing for HIV antibody will be performed, that individual results will be kept confidential to the extent permitted by law, and that appropriate counseling will be offered. Individual counseling of those who are either HIV-antibody positive or at continuing risk for HIV infection is critical for reducing further transmission and for ensuring timely medical care.

Specific recommendations follow:

1. *Persons who may have sexually transmitted disease.* All persons seeking treatment for a sexually transmitted disease, in all health-care settings including the offices of private physicians, should be routinely* counseled and tested for HIV antibody.
2. *IV-drug abusers.* All persons seeking treatment for IV-drug abuse or having a history of IV-drug abuse should be routinely counseled and tested for HIV antibody. Medical professionals in all health-care settings, including prison clinics, should seek a history of IV-drug abuse from patients and should be aware of its implications for HIV infection. In addition, state and local health policy makers should address the following issues:
   - Treatment programs for IV-drug abusers should be sufficiently available to allow persons seeking assistance to enter promptly and be encouraged to alter the behavior that places them and others at risk for HIV infection.
   - Outreach programs for IV-drug abusers should be undertaken to increase their knowledge of AIDS and of ways to prevent HIV infection, to encourage them to obtain counseling and testing for HIV antibody, and to persuade them to be treated for substance abuse.
3. *Persons who consider themselves at risk.* All persons who consider themselves at risk for HIV infection should be counseled and offered testing for HIV antibody.

---

*"Routine counseling and testing" is defined as a policy to provide these services to all clients after informing them that testing will be done. Except where testing is required by law, individuals have the right to decline to be tested without being denied health care or other services.

4. *Women of childbearing age.* All women of childbearing age with identifiable risks for HIV infection should be routinely counseled and tested for HIV antibody, regardless of the health-care setting. Each encounter between a health-care provider and a woman at risk and/or her sexual partners is an opportunity to reach them with information and education about AIDS and prevention of HIV infection. Women are at risk for HIV Infection if they:

    - Have used IV drugs.
    - Have engaged in prostitution.
    - Have had sexual partners who are infected or are at risk for infection because they are bisexual or are IV-drug abusers or hemophiliacs.
    - Are living in communities or were born in countries where there is a known or suspected high prevalence of infection among women.
    - Received a transfusion before blood was being screened for HIV antibody but after HIV infection occurred in the United States (e.g., between 1978 and 1985).

    Educating and testing these women before they become pregnant allows them to avoid pregnancy and subsequent intrauterine perinatal infection of their infants (30%-50% of the infants born to HIV-infected women will also be infected).

    All pregnant women at risk for HIV infection should be routinely counseled and tested for HIV antibody. Identifying pregnant women with HIV infection as early in pregnancy as possible is important for ensuring appropriate medical care for these women; for planning medical care for their infants; and for providing counseling on family planning, future pregnancies, and the risk of sexual transmission of HIV to others.

    All women who seek family planning services and who are at risk for HIV infection should be routinely counseled about AIDS and HIV infection and tested for HIV antibody. Decisions about the need for counseling and testing programs in a community should be based on the best available estimates of the prevalence of HIV infection and the demographic variables of infection.

5. *Persons planning marriage.* All persons considering marriage should be given information about AIDS, HIV infection, and the availability of counseling and testing for HIV antibody. Decisions about instituting routine or mandatory premarital testing for HIV antibody should take into account the prevalence of HIV infection in the area and/or population group as well as other factors and should be based upon the likely cost-effectiveness of such testing in preventing further spread of infection. Premarital testing in an area with a prevalence of HIV infection as low as 0.1% may be justified if reaching an infected person through testing can prevent subsequent transmission to the spouse or prevent pregnancy in a woman who is infected.

6. *Persons undergoing medical evaluation or treatment.* Testing for HIV antibody is a useful diagnostic tool for evaluating patients with selected clinical signs and symptoms such as generalized lymphadenopathy; unexplained dementia; chronic, unexplained fever or diarrhea; unexplained weight loss; or diseases such as tuberculosis as well as sexually transmitted diseases, generalized herpes, and chronic candidiasis.

   Since persons infected with both HIV and the tubercle bacillus are at high risk for severe clinical tuberculosis, all patients with tuberculosis should be routinely counseled and tested for HIV antibody (*6*). Guidelines for managing patients with both HIV and tuberculous infection have been published (*7*).

   The risk of HIV infection from transfusions of blood or blood components from 1978-1985 was greatest for persons receiving large numbers of units of blood collected from areas with high incidences of AIDS. Persons who have this increased risk should be counseled about the potential risk of HIV infection and should be offered antibody testing (*8*).

7. *Persons admitted to hospitals.* Hospitals, in conjunction with state and local health departments, should periodically determine the prevalence of HIV infections in the age groups at highest risk for infection. Consideration should be given to routine testing in those age groups deemed to have a high prevalence of HIV infection.

8. *Persons in correctional systems.* Correctional systems should study the best means of implementing programs for counseling inmates about HIV infection and for testing them for such infection at admission and discharge from the system. In particular, they should examine the usefulness of these programs in preventing further transmission of HIV infection and the impact of the testing programs on both the inmates and the correctional system (*9*). Federal prisons have been instructed to test all prisoners when they enter and leave the prison system.

9. *Prostitutes.* Male and female prostitutes should be counseled and tested and made aware of the risks of HIV infection to themselves and others. Particularly prostitutes who are HIV-antibody positive should be instructed to discontinue the practice of prostitution. Local or state jurisdictions should adopt procedures to assure that these instructions are followed.

Partner Notification/Contact Tracing

Sexual partners and those who share needles with HIV-infected persons are at risk for HIV infection and should be routinely counseled and tested for HIV antibody. Persons who are HIV-antibody positive should be instructed in how to notify their partners and to refer them for counseling and testing. If they are unwilling to notify their partners or if it cannot be assured that their partners will seek counseling, physicians or health department personnel should use confidential procedures to assure that the partners are notified.

Confidentiality and Antidiscrimination Considerations

The ability of health departments, hospitals, and other health-care providers and institutions to assure confidentiality of patient information and the public's confidence in that ability are crucial to efforts to increase the number of persons being counseled and tested for HIV infection. Moreover, to assure broad participation in the counseling and testing programs, it is of equal or greater importance that the public perceive that persons found to be positive will not be subject to inappropriate discrimination.

Every reasonable effort should be made to improve confidentiality of test results. The confidentiality of related records can be improved by a careful review of actual record-keeping practices and by assessing the degree to which these records can be protected under applicable state laws. State laws should be examined and strengthened when found necessary. Because of the wide scope of "need-to-know" situations, because of the possibility of inappropriate disclosures, and because of established authorization procedures for releasing records, it is recognized that there is no perfect solution to confidentiality problems in all situations. Whether disclosures of HIV-testing information are deliberate, inadvertent, or simply unavoidable, public health policy needs to carefully consider ways to reduce the harmful impact of such disclosures.

Public health prevention policy to reduce the transmission of HIV infection can be furthered by an expanded program of counseling and testing for HIV antibody, but the extent to which these programs are successful depends on the level of participation. Persons are more likely to participate in counseling and testing programs if they believe that they will not experience negative consequences in areas such as employment, school admission, housing, and medical services should they test positive. There is no known medical reason to avoid an infected person in these and ordinary social situations since the cumulative evidence is strong that HIV infection is not spread through casual contact. It is essential to the success of counseling and testing programs that persons who are tested for HIV are not subjected to inappropriate discrimination.

References

1. CDC. Additional recommendations to reduce sexual and drug abuse-related transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1986;35:152-5.
2. CDC. Recommended additional guidelines for HIV antibody counseling and testing in the prevention of HIV infection and AIDS. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service, 1987.
3. Burke DS, Brandt BL, Redfield RR, et al. Diagnosis of human immunodeficiency virus infection by immunoassay using a molecularly cloned and expressed virus envelope polypeptide. Ann Intern Med 1987;106:671-6.
4. Meyer KB, Pauker SG. Screening for HIV: can we afford the false positive rate? N Engl J Med 1987;317:238-41.
5. Bayer R, Levine C, Wolf SM. HIV antibody screening: an ethical framework for evaluating proposed programs. JAMA 1986;256:1768-74.
6. CDC. Tuberculosis provisional data—United States, 1986. MMWR 1987;36:254-5.
7. CDC. Diagnosis and management of mycobacterial infection and disease in persons with human T-lymphotropic virus type III/lymphadenopathy-associated virus infection. MMWR 1986;35:448-52.
8. CDC. Human immunodeficiency virus infection in transfusion recipients and their family members. MMWR 1987;36:137-40.
9. Hammett TM. AIDS in correctional facilities: issues and options. 2nd ed. Washington, DC: U.S. Department of Justice, National Institute of Justice, 1987.

Recommendations for Prevention of HIV Transmission in Health-Care Settings

Introduction

Human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS), is transmitted through sexual contact and exposure to infected blood or blood components and perinatally from mother to neonate. HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, breast milk, cerebrospinal fluid, amniotic fluid, and urine and is likely to be isolated from other body fluids, secretions, and excretions. However, epidemiologic evidence has implicated only blood, semen, vaginal secretions, and possibly breast milk in transmission.

The increasing prevalence of HIV increases the risk that health-care workers will be exposed to blood from patients infected with HIV, especially when blood and body-fluid precautions are not followed for all patients. Thus, this document emphasizes the need for health-care workers to consider all patients as potentially infected with HIV and/or other blood-borne pathogens and to adhere rigorously to infection-control precautions for minimizing the risk of exposure to blood and body fluids of all patients.

The recommendations contained in this document consolidate and update CDC recommendations published earlier for preventing HIV transmission in health-care settings: precautions for clinical and laboratory staffs (*1*) and precautions for health-care workers and allied professionals (*2*); recommendations for preventing HIV transmission in the workplace (*3*) and during invasive procedures (*4*); recommendations for preventing possible transmission of HIV from tears (*5*); and recommendations for providing dialysis treatment for HIV-infected patients (*6*). These recommendations also update portions of the "Guideline for Isolation Precautions in Hospitals" (*7*) and reemphasize some of the recommendations contained in "Infection Control Practices for Dentistry" (*8*). The recommendations contained in this document have been developed for use in health-care settings and emphasize the need to treat blood and other body fluids from all patients as potentially infective. These same prudent precautions also should be taken in other settings in which persons may be exposed to blood or other body fluids.

Definition of Health-Care Workers

Health-care workers are defined as persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting.

Health-Care Workers with AIDS

As of July 10, 1987, a total of 1,875 (5.8%) of 32,395 adults with AIDS, who had been reported to the CDC national surveillance system and for whom occupational information was available, reported being employed in a health-care or clinical laboratory setting. In comparison, 6.8 million persons – representing 5.6% of the U.S. labor force – were employed in health services. Of the health-care workers with AIDS, 95% have been reported to exhibit high-risk behavior; for the remaining 5%, the means of HIV acquisition was undetermined. Health-care workers with AIDS were significantly more likely than other workers to have an undetermined risk (5% versus 3%, respectively). For both health-care workers and non-health-care workers with AIDS, the proportion with an undetermined risk has not increased since 1982.

AIDS patients initially reported as not belonging to recognized risk groups are investigated by state and local health departments to determine whether possible risk factors exist. Of all health-care workers with AIDS reported to CDC who were initially characterized as not having an identified risk and for whom follow-up information was available, 66% have been reclassified because risk factors were identified or because the patient was found not to meet the surveillance case definition for AIDS. Of the 87 health-care workers currently categorized as having no identifiable risk, information is incomplete on 16 (18%) because of death or refusal to be interviewed; 38 (44%) are still being investigated. The remaining 33 (38%) health-care workers were interviewed or had other follow-up information available. The occupations of these 33 were as follows: five physicians (15%), three of whom were surgeons; one dentist (3%); three nurses (9%); nine nursing assistants (27%); seven housekeeping or maintenance workers (21%); three clinical laboratory technicians (9%); one therapist (3%); and four others who did not have contact with patients (12%). Although 15 of these 33 health-care workers reported parenteral and/or other non-needlestick exposure to blood or body fluids from patients in the 10 years preceding their diagnosis of AIDS, none of these exposures involved a patient with AIDS or known HIV infection.

Risk to Health-Care Workers of Acquiring HIV in Health-Care Settings

Health-care workers with documented percutaneous or mucous-membrane exposures to blood or body fluids of HIV-infected patients have been prospectively evaluated to determine the risk of infection after such exposures. As of June 30, 1987, 883 health-care workers have been tested for antibody to HIV in an ongoing surveillance project conducted by CDC (*9*). Of these, 708 (80%) had percutaneous exposures to blood, and 175 (20%) had a mucous membrane or an open wound contaminated by blood or body fluid. Of 396 health-care workers, each of whom had only a convalescent-phase serum sample obtained and tested ≥90 days post-exposure, one – for whom heterosexual transmission could not be ruled out – was seropositive for HIV antibody. For 425 additional health-care workers, both acute- and convalescent-phase serum samples were obtained and tested; none of 74 health-care workers with nonpercutaneous exposures seroconverted, and three (0.9%) of 351 with percutaneous exposures seroconverted. None of these three health-care workers had other documented risk factors for infection.

Two other prospective studies to assess the risk of nosocomial acquisition of HIV infection for health-care workers are ongoing in the United States. As of April 30, 1987, 332 health-care workers with a total of 453 needlestick or mucous-membrane exposures to the blood or other body fluids of HIV-infected patients were tested for HIV antibody at the National Institutes of Health (*10*). These exposed workers included 103 with needlestick injuries and 229 with mucous-membrane exposures; none had seroconverted. A similar study at the University of California of 129 health-care workers with documented needlestick injuries or mucous-membrane exposures to blood or other body fluids from patients with HIV infection has not identified any seroconversions (*11*). Results of a prospective study in the United Kingdom identified no evidence of transmission among 150 health-care workers with parenteral or mucous-membrane exposures to blood or other body fluids, secretions, or excretions from patients with HIV infection (*12*).

In addition to health-care workers enrolled in prospective studies, eight persons who provided care to infected patients and denied other risk factors have been reported to have acquired HIV infection. Three of these health-care workers had needlestick exposures to blood from infected patients (*13-15*). Two were persons who provided nursing care to infected persons; although neither sustained a needlestick, both had extensive contact with blood or other body fluids, and neither observed recommended barrier precautions (*16,17*). The other three were health-care workers with non-needlestick exposures to blood from infected patients (*18*). Although the exact route of transmission for these last three infections is not known, all three persons had direct contact of their skin with blood from infected patients, all had skin lesions that may have been contaminated by blood, and one also had a mucous-membrane exposure.

A total of 1,231 dentists and hygienists, many of whom practiced in areas with many AIDS cases, participated in a study to determine the prevalence of antibody to HIV; one dentist (0.1%) had HIV antibody. Although no exposure to a known HIV-infected person could be documented, epidemiologic investigation did not identify any other risk factor for infection. The infected dentist, who also had a history of sustaining needlestick injuries and trauma to his hands, did not routinely wear gloves when providing dental care (*19*).

Precautions To Prevent Transmission of HIV

Universal Precautions

Since medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, blood and body-fluid precautions should be consistently used for **all** patients. This approach, previously recommended by CDC (*3,4*), and referred to as "universal blood and body-fluid precautions" or "universal precautions," should be used in the care of **all** patients, especially including those in emergency-care settings in which the risk of blood exposure is increased and the infection status of the patient is usually unknown (*20*).

1. All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. Gloves should be changed after contact with each patient. Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.
2. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.
3. All health-care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area. Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.
4. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.
5. Health-care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.
6. Pregnant health-care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health-care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

Implementation of universal blood and body-fluid precautions for **all** patients eliminates the need for use of the isolation category of "Blood and Body Fluid Precautions" previously recommended by CDC (*7*) for patients known or suspected to be infected with blood-borne pathogens. Isolation precautions (e.g., enteric, "AFB" [*7*]) should be used as necessary if associated conditions, such as infectious diarrhea or tuberculosis, are diagnosed or suspected.

Precautions for Invasive Procedures

In this document, an invasive procedure is defined as surgical entry into tissues, cavities, or organs or repair of major traumatic injuries 1) in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists. The universal blood and body-fluid precautions listed above, combined with the precautions listed below, should be the minimum precautions for all such invasive procedures.

1. All health-care workers who participate in invasive procedures must routinely use appropriate barrier precautions to prevent skin and mucous-membrane contact with blood and other body fluids of all patients. Gloves and surgical masks must be worn for all invasive procedures. Protective eyewear or face shields should be worn for procedures that commonly result in the generation of droplets, splashing of blood or other body fluids, or the generation of bone chips. Gowns or aprons made of materials that provide an effective barrier should be worn during invasive procedures that are likely to result in the splashing of blood or other body fluids. All health-care workers who perform or assist in vaginal or cesarean deliveries should wear gloves and gowns when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin and should wear gloves during post-delivery care of the umbilical cord.
2. If a glove is torn or a needlestick or other injury occurs, the glove should be removed and a new glove used as promptly as patient safety permits; the needle or instrument involved in the incident should also be removed from the sterile field.

Precautions for Dentistry*

Blood, saliva, and gingival fluid from all dental patients should be considered infective. Special emphasis should be placed on the following precautions for preventing transmission of blood-borne pathogens in dental practice in both institutional and non-institutional settings.

1. In addition to wearing gloves for contact with oral mucous membranes of all patients, all dental workers should wear surgical masks and protective eyewear or chin-length plastic face shields during dental procedures in which splashing or spattering of blood, saliva, or gingival fluids is likely. Rubber dams, high-speed evacuation, and proper patient positioning, when appropriate, should be utilized to minimize generation of droplets and spatter.
2. Handpieces should be sterilized after use with each patient, since blood, saliva, or gingival fluid of patients may be aspirated into the handpiece or waterline. Handpieces that cannot be sterilized should at least be flushed, the outside surface cleaned and wiped with a suitable chemical germicide, and then rinsed. Handpieces should be flushed at the beginning of the day and after use with each patient. Manufacturers' recommendations should be followed for use and maintenance of waterlines and check valves and for flushing of handpieces. The same precautions should be used for ultrasonic scalers and air/water syringes.

---

*General infection-control precautions are more specifically addressed in previous recommendations for infection-control practices for dentistry (*8*).

3. Blood and saliva should be thoroughly and carefully cleaned from material that has been used in the mouth (e.g., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Contaminated materials, impressions, and intra-oral devices should also be cleaned and disinfected before being handled in the dental laboratory and before they are placed in the patient's mouth. Because of the increasing variety of dental materials used intra-orally, dental workers should consult with manufacturers as to the stability of specific materials when using disinfection procedures.
4. Dental equipment and surfaces that are difficult to disinfect (e.g., light handles or X-ray-unit heads) and that may become contaminated should be wrapped with impervious-backed paper, aluminum foil, or clear plastic wrap. The coverings should be removed and discarded, and clean coverings should be put in place after use with each patient.

Precautions for Autopsies or Morticians' Services

In addition to the universal blood and body-fluid precautions listed above, the following precautions should be used by persons performing postmortem procedures:

1. All persons performing or assisting in postmortem procedures should wear gloves, masks, protective eyewear, gowns, and waterproof aprons.
2. Instruments and surfaces contaminated during postmortem procedures should be decontaminated with an appropriate chemical germicide.

Precautions for Dialysis

Patients with end-stage renal disease who are undergoing maintenance dialysis and who have HIV infection can be dialyzed in hospital-based or free-standing dialysis units using conventional infection-control precautions (*21*). Universal blood and body-fluid precautions should be used when dialyzing all patients.

Strategies for disinfecting the dialysis fluid pathways of the hemodialysis machine are targeted to control bacterial contamination and generally consist of using 500-750 parts per million (ppm) of sodium hypochlorite (household bleach) for 30-40 minutes or 1.5%-2.0% formaldehyde overnight. In addition, several chemical germicides formulated to disinfect dialysis machines are commercially available. None of these protocols or procedures need to be changed for dialyzing patients infected with HIV.

Patients infected with HIV can be dialyzed by either hemodialysis or peritoneal dialysis and do not need to be isolated from other patients. The type of dialysis treatment (i.e., hemodialysis or peritoneal dialysis) should be based on the needs of the patient. The dialyzer may be discarded after each use. Alternatively, centers that reuse dialyzers—i.e., a specific single-use dialyzer is issued to a specific patient, removed, cleaned, disinfected, and reused several times on the same patient only—may include HIV-infected patients in the dialyzer-reuse program. An individual dialyzer must never be used on more than one patient.

Precautions for Laboratories[†]

Blood and other body fluids from all patients should be considered infective. To supplement the universal blood and body-fluid precautions listed above, the following precautions are recommended for health-care workers in clinical laboratories.

[†] Additional precautions for research and industrial laboratories are addressed elsewhere (*22,23*).

1. All specimens of blood and body fluids should be put in a well-constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and of the laboratory form accompanying the specimen.
2. All persons processing blood and body-fluid specimens (e.g., removing tops from vacuum tubes) should wear gloves. Masks and protective eyewear should be worn if mucous-membrane contact with blood or body fluids is anticipated. Gloves should be changed and hands washed after completion of specimen processing.
3. For routine procedures, such as histologic and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, biological safety cabinets (Class I or II) should be used whenever procedures are conducted that have a high potential for generating droplets. These include activities such as blending, sonicating, and vigorous mixing.
4. Mechanical pipetting devices should be used for manipulating all liquids in the laboratory. Mouth pipetting must not be done.
5. Use of needles and syringes should be limited to situations in which there is no alternative, and the recommendations for preventing injuries with needles outlined under universal precautions should be followed.
6. Laboratory work surfaces should be decontaminated with an appropriate chemical germicide after a spill of blood or other body fluids and when work activities are completed.
7. Contaminated materials used in laboratory tests should be decontaminated before reprocessing or be placed in bags and disposed of in accordance with institutional policies for disposal of infective waste (*24*).
8. Scientific equipment that has been contaminated with blood or other body fluids should be decontaminated and cleaned before being repaired in the laboratory or transported to the manufacturer.
9. All persons should wash their hands after completing laboratory activities and should remove protective clothing before leaving the laboratory.

Implementation of universal blood and body-fluid precautions for all patients eliminates the need for warning labels on specimens since blood and other body fluids from all patients should be considered infective.

Environmental Considerations for HIV Transmission

No environmentally mediated mode of HIV transmission has been documented. Nevertheless, the precautions described below should be taken routinely in the care of all patients.

Sterilization and Disinfection

Standard sterilization and disinfection procedures for patient-care equipment currently recommended for use (*25,26*) in a variety of health-care settings—including hospitals, medical and dental clinics and offices, hemodialysis centers, emergency-care facilities, and long-term nursing-care facilities—are adequate to sterilize or disinfect instruments, devices, or other items contaminated with blood or other body fluids from persons infected with blood-borne pathogens including HIV (*21,23*).

Instruments or devices that enter sterile tissue or the vascular system of any patient or through which blood flows should be sterilized before reuse. Devices or items that contact intact mucous membranes should be sterilized or receive high-level disinfection, a procedure that kills vegetative organisms and viruses but not necessarily large numbers of bacterial spores. Chemical germicides that are registered with the U.S. Environmental Protection Agency (EPA) as "sterilants" may be used either for sterilization or for high-level disinfection depending on contact time.

Contact lenses used in trial fittings should be disinfected after each fitting by using a hydrogen peroxide contact lens disinfecting system or, if compatible, with heat (78 C-80 C [172.4 F-176.0 F]) for 10 minutes.

Medical devices or instruments that require sterilization or disinfection should be thoroughly cleaned before being exposed to the germicide, and the manufacturer's instructions for the use of the germicide should be followed. Further, it is important that the manufacturer's specifications for compatibility of the medical device with chemical germicides be closely followed. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, SW, Washington, D.C. 20460.

Studies have shown that HIV is inactivated rapidly after being exposed to commonly used chemical germicides at concentrations that are much lower than used in practice (*27-30*). Embalming fluids are similar to the types of chemical germicides that have been tested and found to completely inactivate HIV. In addition to commercially available chemical germicides, a solution of sodium hypochlorite (household bleach) prepared daily is an inexpensive and effective germicide. Concentrations ranging from approximately 500 ppm (1:100 dilution of household bleach) sodium hypochlorite to 5,000 ppm (1:10 dilution of household bleach) are effective depending on the amount of organic material (e.g., blood, mucus) present on the surface to be cleaned and disinfected. Commercially available chemical germicides may be more compatible with certain medical devices that might be corroded by repeated exposure to sodium hypochlorite, especially to the 1:10 dilution.

Survival of HIV in the Environment

The most extensive study on the survival of HIV after drying involved greatly concentrated HIV samples, i.e., 10 million tissue-culture infectious doses per milliliter (*31*). This concentration is at least 100,000 times greater than that typically found in the blood or serum of patients with HIV infection. HIV was detectable by tissue-culture techniques 1-3 days after drying, but the rate of inactivation was rapid. Studies performed at CDC have also shown that drying HIV causes a rapid (within several hours) 1-2 log (90%-99%) reduction in HIV concentration. In tissue-culture fluid, cell-free HIV could be detected up to 15 days at room temperature, up to 11 days at 37 C (98.6 F), and up to 1 day if the HIV was cell-associated.

When considered in the context of environmental conditions in health-care facilities, these results do not require any changes in currently recommended sterilization, disinfection, or housekeeping strategies. When medical devices are contaminated with blood or other body fluids, existing recommendations include the cleaning of these instruments, followed by disinfection or sterilization, depending on the type of medical device. These protocols assume "worst-case" conditions of extreme virologic and microbiologic contamination, and whether viruses have been inactivated after drying plays no role in formulating these strategies. Consequently, no changes in published procedures for cleaning, disinfecting, or sterilizing need to be made.

Housekeeping

Environmental surfaces such as walls, floors, and other surfaces are not associated with transmission of infections to patients or health-care workers. Therefore, extraordinary attempts to disinfect or sterilize these environmental surfaces are not necessary. However, cleaning and removal of soil should be done routinely.

Cleaning schedules and methods vary according to the area of the hospital or institution, type of surface to be cleaned, and the amount and type of soil present. Horizontal surfaces (e.g., bedside tables and hard-surfaced flooring) in patient-care areas are usually cleaned on a regular basis, when soiling or spills occur, and when a patient is discharged. Cleaning of walls, blinds, and curtains is recommended only if they are visibly soiled. Disinfectant fogging is an unsatisfactory method of decontaminating air and surfaces and is not recommended.

Disinfectant-detergent formulations registered by EPA can be used for cleaning environmental surfaces, but the actual physical removal of microorganisms by scrubbing is probably at least as important as any antimicrobial effect of the cleaning agent used. Therefore, cost, safety, and acceptability by housekeepers can be the main criteria for selecting any such registered agent. The manufacturers' instructions for appropriate use should be followed.

Cleaning and Decontaminating Spills of Blood or Other Body Fluids

Chemical germicides that are approved for use as "hospital disinfectants" and are tuberculocidal when used at recommended dilutions can be used to decontaminate spills of blood and other body fluids. Strategies for decontaminating spills of blood and other body fluids in a patient-care setting are different than for spills of cultures or other materials in clinical, public health, or research laboratories. In patient-care areas, visible material should first be removed and then the area should be decontaminated. With large spills of cultured or concentrated infectious agents in the laboratory, the contaminated area should be flooded with a liquid germicide before cleaning, then decontaminated with fresh germicidal chemical. In both settings, gloves should be worn during the cleaning and decontaminating procedures.

Laundry

Although soiled linen has been identified as a source of large numbers of certain pathogenic microorganisms, the risk of actual disease transmission is negligible. Rather than rigid procedures and specifications, hygienic and common-sense storage and processing of clean and soiled linen are recommended (*26*). Soiled linen should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen. All soiled linen should be bagged at the location where it was used; it should not be sorted or rinsed in patient-care areas. Linen soiled with blood or body fluids should be placed and transported in bags that prevent leakage. If hot water is used, linen should be washed with detergent in water at least 71 C (160 F) for 25 minutes. If low-temperature(≤70 C [158 F]) laundry cycles are used, chemicals suitable for low-temperature washing at proper use concentration should be used.

Infective Waste

There is no epidemiologic evidence to suggest that most hospital waste is any more infective than residential waste. Moreover, there is no epidemiologic evidence that hospital waste has caused disease in the community as a result of improper disposal. Therefore, identifying wastes for which special precautions are indicated is largely a matter of judgment about the relative risk of disease transmission. The most practical approach to the management of infective waste is to identify those wastes with the potential for causing infection during handling and disposal and for which some special precautions appear prudent. Hospital wastes for which special precautions appear prudent include microbiology laboratory waste, pathology waste, and blood specimens or blood products. While any item that has had contact with blood, exudates, or secretions may be potentially infective, it is not usually considered practical or necessary to treat all such waste as infective (*23,26*). Infective waste, in general, should either be incinerated or should be autoclaved before disposal in a sanitary landfill. Bulk blood, suctioned fluids, excretions, and secretions may be carefully poured down a drain connected to a sanitary sewer. Sanitary sewers may also be used to dispose of other infectious wastes capable of being ground and flushed into the sewer.

Implementation of Recommended Precautions

Employers of health-care workers should ensure that policies exist for:

1. Initial orientation and continuing education and training of all health-care workers—including students and trainees—on the epidemiology, modes of transmission, and prevention of HIV and other blood-borne infections and the need for routine use of universal blood and body-fluid precautions for **all** patients.
2. Provision of equipment and supplies necessary to minimize the risk of infection with HIV and other blood-borne pathogens.
3. Monitoring adherence to recommended protective measures. When monitoring reveals a failure to follow recommended precautions, counseling, education, and/or re-training should be provided, and, if necessary, appropriate disciplinary action should be considered.

Professional associations and labor organizations, through continuing education efforts, should emphasize the need for health-care workers to follow recommended precautions.

Serologic Testing for HIV Infection

Background

A person is identified as infected with HIV when a sequence of tests, starting with repeated enzyme immunoassays (EIA) and including a Western blot or similar, more specific assay, are repeatedly reactive. Persons infected with HIV usually develop antibody against the virus within 6-12 weeks after infection.

The sensitivity of the currently licensed EIA tests is at least 99% when they are performed under optimal laboratory conditions on serum specimens from persons infected for ≥12 weeks. Optimal laboratory conditions include the use of reliable reagents, provision of continuing education of personnel, quality control of procedures, and participation in performance-evaluation programs. Given this performance, the probability of a false-negative test is remote except during the first several weeks after infection, before detectable antibody is present. The proportion of infected persons with a false-negative test attributed to absence of antibody in the early stages of infection is dependent on both the incidence and prevalence of HIV infection in a population (Table 1).

The specificity of the currently licensed EIA tests is approximately 99% when repeatedly reactive tests are considered. Repeat testing of initially reactive specimens by EIA is required to reduce the likelihood of laboratory error. To increase further the specificity of serologic tests, laboratories must use a supplemental test, most often the Western blot, to validate repeatedly reactive EIA results. Under optimal laboratory conditions, the sensitivity of the Western blot test is comparable to or greater than that of a repeatedly reactive EIA, and the Western blot is highly specific when strict criteria are used to interpret the test results. The testing sequence of a repeatedly reactive EIA and a positive Western blot test is highly predictive of HIV infection, even in a population with a low prevalence of infection (Table 2). If the Western blot test result is indeterminant, the testing sequence is considered equivocal for HIV infection.

TABLE 1. Estimated annual number of patients infected with HIV not detected by HIV-antibody testing in a hypothetical hospital with 10,000 admissions/year*

Beginning prevalence of HIV infection	Annual incidence of HIV infection	Approximate number of HIV-infected patients	Approximate number of HIV-infected patients not detected
5.0%	1.0%	550	17-18
5.0%	0.5%	525	11-12
1.0%	0.2%	110	3-4
1.0%	0.1%	105	2-3
0.1%	0.02%	11	0-1
0.1%	0.01%	11	0-1

*The estimates are based on the following assumptions: 1) the sensitivity of the screening test is 99% (i.e., 99% of HIV-infected persons with antibody will be detected); 2) persons infected with HIV will not develop detectable antibody (seroconvert) until 6 weeks (1.5 months) after infection; 3) new infections occur at an equal rate throughout the year; 4) calculations of the number of HIV-infected persons in the patient population are based on the mid-year prevalence, which is the beginning prevalence plus half the annual incidence of infections.

When this occurs, the Western blot test should be repeated on the same serum sample, and, if still indeterminant, the testing sequence should be repeated on a sample collected 3-6 months later. Use of other supplemental tests may aid in interpreting of results on samples that are persistently indeterminant by Western blot.

Testing of Patients

Previous CDC recommendations have emphasized the value of HIV serologic testing of patients for: 1) management of parenteral or mucous-membrane exposures of health-care workers, 2) patient diagnosis and management, and 3) counseling and serologic testing to prevent and control HIV transmission in the community. In addition, more recent recommendations have stated that hospitals, in conjunction with state and local health departments, should periodically determine the prevalence of HIV infection among patients from age groups at highest risk of infection (*32*).

Adherence to universal blood and body-fluid precautions recommended for the care of all patients will minimize the risk of transmission of HIV and other blood-borne pathogens from patients to health-care workers. The utility of routine HIV serologic testing of patients as an adjunct to universal precautions is unknown. Results of such testing may not be available in emergency or outpatient settings. In addition, some recently infected patients will not have detectable antibody to HIV (Table 1).

Personnel in some hospitals have advocated serologic testing of patients in settings in which exposure of health-care workers to large amounts of patients' blood may be anticipated. Specific patients for whom serologic testing has been advocated include those undergoing major operative procedures and those undergoing treatment in critical-care units, especially if they have conditions involving uncontrolled bleeding. Decisions regarding the need to establish testing programs for patients should be made by physicians or individual institutions. In addition, when deemed appropriate, testing of individual patients may be performed on agreement between the patient and the physician providing care.

In addition to the universal precautions recommended for all patients, certain additional precautions for the care of HIV-infected patients undergoing major surgical operations have been proposed by personnel in some hospitals. For example, surgical procedures on an HIV-infected patient might be altered so that hand-to-hand passing of sharp instruments would be eliminated; stapling instruments rather than

TABLE 2. Predictive value of positive HIV-antibody tests in hypothetical populations with different prevalences of infection

	Prevalence of infection	Predictive value of positive test[*]
Repeatedly reactive enzyme immunoassay (EIA)[†]	0.2%	28.41%
	2.0%	80.16%
	20.0%	98.02%
Repeatedly reactive EIA followed by positive Western blot (WB)[§]	0.2%	99.75%
	2.0%	99.97%
	20.0%	99.99%

[*] Proportion of persons with positive test results who are actually infected with HIV.
[†] Assumes EIA sensitivity of 99.0% and specificity of 99.5%.
[§] Assumes WB sensitivity of 99.0% and specificity of 99.9%.

hand-suturing equipment might be used to perform tissue approximation; electrocautery devices rather than scalpels might be used as cutting instruments; and, even though uncomfortable, gowns that totally prevent seepage of blood onto the skin of members of the operative team might be worn. While such modifications might further minimize the risk of HIV infection for members of the operative team, some of these techniques could result in prolongation of operative time and could potentially have an adverse effect on the patient.

Testing programs, if developed, should include the following principles:

- Obtaining consent for testing.
- Informing patients of test results, and providing counseling for seropositive patients by properly trained persons.
- Assuring that confidentiality safeguards are in place to limit knowledge of test results to those directly involved in the care of infected patients or as required by law.
- Assuring that identification of infected patients will not result in denial of needed care or provision of suboptimal care.
- Evaluating prospectively 1) the efficacy of the program in reducing the incidence of parenteral, mucous-membrane, or significant cutaneous exposures of health-care workers to the blood or other body fluids of HIV-infected patients and 2) the effect of modified procedures on patients.

Testing of Health-Care Workers

Although transmission of HIV from infected health-care workers to patients has not been reported, transmission during invasive procedures remains a possibility. Transmission of hepatitis B virus (HBV)—a blood-borne agent with a considerably greater potential for nosocomial spread—from health-care workers to patients has been documented. Such transmission has occurred in situations (e.g., oral and gynecologic surgery) in which health-care workers, when tested, had very high concentrations of HBV in their blood (at least 100 million infectious virus particles per milliliter, a concentration much higher than occurs with HIV infection), and the health-care workers sustained a puncture wound while performing invasive procedures or had exudative or weeping lesions or microlacerations that allowed virus to contaminate instruments or open wounds of patients (*33,34*).

The hepatitis B experience indicates that only those health-care workers who perform certain types of invasive procedures have transmitted HBV to patients. Adherence to recommendations in this document will minimize the risk of transmission of HIV and other blood-borne pathogens from health-care workers to patients during invasive procedures. Since transmission of HIV from infected health-care workers performing invasive procedures to their patients has not been reported and would be expected to occur only very rarely, if at all, the utility of routine testing of such health-care workers to prevent transmission of HIV cannot be assessed. If consideration is given to developing a serologic testing program for health-care workers who perform invasive procedures, the frequency of testing, as well as the issues of consent, confidentiality, and consequences of test results—as previously outlined for testing programs for patients—must be addressed.

Management of Infected Health-Care Workers

Health-care workers with impaired immune systems resulting from HIV infection or other causes are at increased risk of acquiring or experiencing serious complications of infectious disease. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., measles, varicella). Any health-care worker with an impaired immune system should be counseled about the potential risk associated with taking care of patients with any transmissible infection and should continue to follow existing recommendations for infection control to minimize risk of exposure to other infectious agents (*7,35*). Recommendations of the Immunization Practices Advisory Committee (ACIP) and institutional policies concerning requirements for vaccinating health-care workers with live-virus vaccines (e.g., measles, rubella) should also be considered.

The question of whether workers infected with HIV – especially those who perform invasive procedures – can adequately and safely be allowed to perform patient-care duties or whether their work assignments should be changed must be determined on an individual basis. These decisions should be made by the health-care worker's personal physician(s) in conjunction with the medical directors and personnel health service staff of the employing institution or hospital.

Management of Exposures

If a health-care worker has a parenteral (e.g., needlestick or cut) or mucous-membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids or has a cutaneous exposure involving large amounts of blood or prolonged contact with blood – especially when the exposed skin is chapped, abraded, or afflicted with dermatitis – the source patient should be informed of the incident and tested for serologic evidence of HIV infection after consent is obtained. Policies should be developed for testing source patients in situations in which consent cannot be obtained (e.g., an unconscious patient).

If the source patient has AIDS, is positive for HIV antibody, or refuses the test, the health-care worker should be counseled regarding the risk of infection and evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure. The health-care worker should be advised to report and seek medical evaluation for any acute febrile illness that occurs within 12 weeks after the exposure. Such an illness – particularly one characterized by fever, rash, or lymphadenopathy – may be indicative of recent HIV infection. Seronegative health-care workers should be retested 6 weeks post-exposure and on a periodic basis thereafter (e.g., 12 weeks and 6 months after exposure) to determine whether transmission has occurred. During this follow-up period – especially the first 6-12 weeks after exposure, when most infected persons are expected to seroconvert – exposed health-care workers should follow U.S. Public Health Service (PHS) recommendations for preventing transmission of HIV (*36,37*).

No further follow-up of a health-care worker exposed to infection as described above is necessary if the source patient is seronegative unless the source patient is at high risk of HIV infection. In the latter case, a subsequent specimen (e.g., 12 weeks following exposure) may be obtained from the health-care worker for antibody testing. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized. Serologic testing should be available to all health-care workers who are concerned that they may have been infected with HIV.

If a patient has a parenteral or mucous-membrane exposure to blood or other body fluid of a health-care worker, the patient should be informed of the incident, and the same procedure outlined above for management of exposures should be followed for both the source health-care worker and the exposed patient.

References

1. CDC. Acquired immunodeficiency syndrome (AIDS): Precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
2. CDC. Acquired immunodeficiency syndrome (AIDS): Precautions for health-care workers and allied professionals. MMWR 1983;32:450-1.
3. CDC. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. MMWR 1985;34:681-6, 691-5.
4. CDC. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus during invasive procedures. MMWR 1986;35:221-3.
5. CDC. Recommendations for preventing possible transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus from tears. MMWR 1985;34:533-4.
6. CDC. Recommendations for providing dialysis treatment to patients infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus infection. MMWR 1986;35:376-8, 383.
7. Garner JS, Simmons BP. Guideline for isolation precautions in hospitals. Infect Control 1983;4 (suppl) :245-325.
8. CDC. Recommended infection control practices for dentistry. MMWR 1986;35:237-42.
9. McCray E, The Cooperative Needlestick Surveillance Group. Occupational risk of the acquired immunodeficiency syndrome among health care workers. N Engl J Med 1986;314:1127-32.
10. Henderson DK, Saah AJ, Zak BJ, et al. Risk of nosocomial infection with human T-cell lymphotropic virus type III/lymphadenopathy-associated virus in a large cohort of intensively exposed health care workers. Ann Intern Med 1986;104:644-7.
11. Gerberding JL, Bryant-LeBlanc CE, Nelson K, et al. Risk of transmitting the human immunodeficiency virus, cytomegalovirus, and hepatitis B virus to health care workers exposed to patients with AIDS and AIDS-related conditions. J Infect Dis 1987;156:1-8.
12. McEvoy M, Porter K, Mortimer P, Simmons N, Shanson D. Prospective study of clinical, laboratory, and ancillary staff with accidental exposures to blood or other body fluids from patients infected with HIV. Br Med J 1987;294:1595-7.
13. Anonymous. Needlestick transmission of HTLV-III from a patient infected in Africa. Lancet 1984;2:1376-7.
14. Oksenhendler E, Harzic M, Le Roux JM, Rabian C, Clauvel JP. HIV infection with seroconversion after a superficial needlestick injury to the finger. N Engl J Med 1986;315:582.
15. Neisson-Vernant C, Arfi S, Mathez D, Leibowitch J, Monplaisir N. Needlestick HIV seroconversion in a nurse. Lancet 1986;2:814.
16. Grint P, McEvoy M. Two associated cases of the acquired immune deficiency syndrome (AIDS). PHLS Commun Dis Rep 1985;42:4.
17. CDC. Apparent transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus from a child to a mother providing health care. MMWR 1986;35:76-9.
18. CDC. Update: Human immunodeficiency virus infections in health-care workers exposed to blood of infected patients. MMWR 1987;36:285-9.
19. Kline RS, Phelan J, Friedland GH, et al. Low occupational risk for HIV infection for dental professionals [Abstract]. In: Abstracts from the III International Conference on AIDS, 1-5 June 1985. Washington, DC: 155.
20. Baker JL, Kelen GD, Sivertson KT, Quinn TC. Unsuspected human immunodeficiency virus in critically ill emergency patients. JAMA 1987;257:2609-11.
21. Favero MS. Dialysis-associated diseases and their control. In: Bennett JV, Brachman PS, eds. Hospital infections. Boston: Little, Brown and Company, 1985:267-84.

22. Richardson JH, Barkley WE, eds. Biosafety in microbiological and biomedical laboratories, 1984. Washington, DC : US Department of Health and Human Services, Public Health Service. HHS publication no. (CDC) 84-8395.
23. CDC. Human T-lymphotropic virus type III/lymphadenopathy-associated virus: Agent summary statement. MMWR 1986;35:540-2, 547-9.
24. Environmental Protection Agency. EPA guide for infectious waste management. Washington, DC :U.S. Environmental Protection Agency, May 1986 (Publication no. EPA/530-SW-86-014).
25. Favero MS. Sterilization, disinfection, and antisepsis in the hospital. In: Manual of clinical microbiology. 4th ed. Washington, DC: American Society for Microbiology, 1985;129-37.
26. Garner JS, Favero MS. Guideline for handwashing and hospital environmental control, 1985. Atlanta: Public Health Service, Centers for Disease Control, 1985. HHS publication no. 99-1117.
27. Spire B, Montagnier L, Barré-Sinoussi F, Chermann JC. Inactivation of lymphadenopathy associated virus by chemical disinfectants. Lancet 1984;2:899-901.
28. Martin LS, McDougal JS, Loskoski SL. Disinfection and inactivation of the human T lymphotropic virus type III/lymphadenopathy-associated virus. J Infect Dis 1985; 152:400-3.
29. McDougal JS, Martin LS, Cort SP, et al. Thermal inactivation of the acquired immunodeficiency syndrome virus-III/lymphadenopathy-associated virus, with special reference to antihemophilic factor. J Clin Invest 1985;76:875-7.
30. Spire B, Barré-Sinoussi F, Dormont D, Montagnier L, Chermann JC. Inactivation of lymphadenopathy-associated virus by heat, gamma rays, and ultraviolet light. Lancet 1985;1:188-9.
31. Resnik L, Veren K, Salahuddin SZ, Tondreau S, Markham PD. Stability and inactivation of HTLV-III/LAV under clinical and laboratory environments. JAMA 1986;255:1887-91.
32. CDC. Public Health Service (PHS) guidelines for counseling and antibody testing to prevent HIV infection and AIDS. MMWR 1987;3:509-15..
33. Kane MA, Lettau LA. Transmission of HBV from dental personnel to patients. J Am Dent Assoc 1985;110:634-6.
34. Lettau LA, Smith JD, Williams D, et. al. Transmission of hepatitis B with resultant restriction of surgical practice. JAMA 1986;255:934-7.
35. Williams WW. Guideline for infection control in hospital personnel. Infect Control 1983;4 (suppl) :326-49.
36. CDC. Prevention of acquired immune deficiency syndrome (AIDS): Report of inter-agency recommendations. MMWR 1983;32:101-3.
37. CDC. Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. MMWR 1985;34:1-5.

APPENDIX F

Forms for Inmate Screening and History Taking

DC 478
NEW 5,'87

CONFIDENTIAL

NORTH CAROLINA DEPARTMENT OF CORRECTION
DIVISION OF PRISONS
HEALTH SERVICES SECTION

HIV SCREENING REPORT

***NOTE**: Information listed hereon is strictly confidential medical information and should not be shared or discussed with individuals who are not responsible for or directly involved in the Department of Correction Health Care Delivery System.

INMATE NAME:______________________________________

PRISON NO. :__________________ CUSTODY STATUS:________________

LOCATION :__________________ BIRTH PLACE:________________

ADMISSION DATE:______________ADMISSION LOCATION:______________

DATE ARRIVED AT CURRENT UNIT:________________

LENGTH OF TIME AT PREVIOUS UNIT________________

I. **PATIENT HISTORY:**

A. **Sexual History:**

(1) Sex of Partners_____ (Risk behavior occurred before or after 1978?) ____________________

(2) Number of Partners ____________________

(3) Anonymous Partners ____________________

(4) Contact with Prostitutes ________________

(5) Geographical area of high risk behavior (e.g. New York City, California, New Jersey, Florida) ____________________

(6) Types of sex acts (receptive anal intercourse, vaginal, oral sex) ____________________

B. **Life-Style History:**

(1) IV Drug Use (Shared needles?) ____________
(2) Has patient given blood? _____YES _____NO
(If yes, when ___________ where___________)

(3) Occupation (does work bring patient into contact with infectious body fluids?) ____YES _____NO

CONFIDENTIAL

Inmate Name: ______________________ Prison No. __________________

II. CLINICAL HISTORY:

A. Date of Onset of Symptoms ______________________

B. Symptoms Experienced:

(1) Dry Itchy Skin ___
(2) Malaise ___
(3) Cough ___
(4) Shortness of Breath ___
(5) Chills ___
(6) Chronic Rash ___
(7) Oral Lesions ___
(8) Flu-Like Symptoms ___
(9) Chest Pains ___
(10) Loss of Appetite ___
(11) Headache ___
(12) Candidiasis ___
(13) Genital/Rectal Symptoms ___
(14) GI Problems:
    - Diarrhea ___
    - Nausea ___
    - Vomiting ___
    - Abdominal Pain ___
(15) Dyspnea Upon Exertion ___
(16) Dysphagia ___
(17) Fever: ___
    Greater than 100 F - (Intermittent or continuous, For at least 3 months, in absence of other identifiable cause)
(18) Weight Loss: ___
    (10% normal body weight, or ≥ 15 pounds)
(19) Lymphadenopathy: ___
    (Persistent over 3 mos., involving ≥ 2 extra-inguinal node-bearing areas)
(20) Diarrhea: ___
    (Intermittent or continuous, ≥ three months, in absence of other identifiable cause)
(21) Fatigue: ___
    to the point of decreased physical/mental function
(22) Night Sweats: ___
    (Intermittent or continuous, ≥ three months, in absence of other identifiable cause)

DC 478
NEW 5/87

CONFIDENTIAL

Inmate Name: ______________________ Prison No. __________________

III. LABORATORY:

A. HIV (HTLV III) Antibody: + -

B. Western Blot : + -

C. WBC : _____

D. Platelets : _____

E. Lymphocytes : _____

F. Cultures : _____

G. CXR : _____

H. Stool For O + P/Culture: _____

I. Other : _____

J. Depressed helper T-cell: _____
(≥ 2 standard deviations below the mean)

K. Depressed helper/
suppressor ratio : _____
(≥ standard deviations below the mean)

L. At least one of the following:
- Leukopenia : _____
- Thrombocytopenia : _____
- Absolute lymphopenia : _____
- Absolute Anemia : _____

M. Elevated serum globulins: _____

N. Depressed blastogenesis:
- Pokeweed : _____
- Phytohemagglutinin : _____
  (PHA mitogens)

O. Abnormal intradermal tests: ____
for delayed cutaneous hypersensitivity
(using Multi-Test or equivalent)

IV. CURRENT PRESUMPTIVE DIAGNOSIS OF STAGE OF HIV INFECTION:

A. HIV Seropositive (No symptoms) __________________

B. AIDS Related Complex (2 Lab + 2 Clinical Abnormalities) ____________________________________

C. AIDS (Presence of opportunistic infection/ cancer) ____________________________________
- If a stated case, where diagnosed? ______________
- By whom? ________________________________

D. Suspect (unsure of exact diagnosis) ________________

C O N F I D E N T I A L

Inmate Name:______________________ Prison No.__________________

V. COUNSELING:

A. Patient given "Information for Persons with a Positive HIV Antibody Test Result" _____ YES _____ NO

B. Patient counseled according to "Health Services Counseling Check Off Sheet - HIV Antibody Seropositives" _____ YES _____ NO

C. Date of Counseling ______________ Time_______

D. Name of Counselor ______________________________

VI. DISPOSITION:

A. Was this patient sent for further evaluation to:

Central Prison Hospital _____
McCain Hospital _____
NC Correctional Center for Women _____
Western Correctional Center _____

(Signature) (Title) (Date)

NOTE: Please contact CPH, McCain Hospital, NCCCW, WCC, and discuss AIDS-related referrals prior to sending patient

CP Hospital	- (919)	834-0130 ex.407
McCain Hospital	- (919)	944-2351
NCCCW	- (919)	733-4891
Western Cor. Ctr.	- (704)	437-8335

Please send a copy of this screening report to appropriate unit with the patient

Send completed HIV Screening Report in a sealed envelope marked "CONFIDENTIAL" to:

Director - Health Services
831 West Morgan Street
Raleigh, NC 27603

DEPARTMENT OF CORRECTIONS
Iowa Medical and Classification Center
Health Services

AIDS SCREENING: HEALTH HISTORY

1. Inmate Number ____________ 2. Admit Date ____________
3. Sex: _____ Male _____ Female 4. Birthdate ____________
5. Height ________ 6. Weight ________ 7. BP ______ 8. PPD ________
9. Ethnic Background: _____ White _____ American Indian
_____ Black _____ Other ____________
_____ Hispanic (i.e., Cuban, Puerto Rican, Mexican)

10. USE OF IV DRUGS: History of IV drug use _____ Yes _____ No

If Yes: a. Date of last usage ____________
b. Avg. frequency of use ____________
c. Duration of use (mos./yrs.) ____________
d. Shared needle usage _____ Yes _____ No

11. USE OF OTHER DRUGS: _____ Yes _____ No

If Yes: a. Circle types: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
b. Date of last usage ____________
c. Avg. frequency of use ____________
d. Duration of use (mos./yrs.) ____________
e. Poppers (Amyl Nitrate): _____ Yes _____ No

12. USE OF ALCOHOL: _____ Yes _____ No

If Yes: a. Date of last usage ____________
b. Avg. frequency of use ____________
c. Duration of use (mos./yrs.) ____________

13. SEXUAL HISTORY:

a. Age of 1st sexual contact ____________
b. Number of different sexual contacts per week/month ____________
c. Approximate date of last contact ____________
d. Sexual preference: _____ heterosexual; _____ bisexual; _____ homosexual
e. If male bisexual or homosexual:

1. Date of last homosexual activity ____________
2. Average frequency of homosexual activity (per wk./mo.) ____________
3. Duration of homosexual activity (mos./yrs.) ____________
4. Anal intercourse _____ Yes _____ No

If Yes: Anal initiator _____
Anal recipient _____
Both _____

5. Oral intercourse _____ Yes _____ No
6. Fist intercourse _____ Yes _____ No
7. Number of different partners per month ____________

f. Frequency of use of condoms: _____ always; _____ sometimes; _____ never

14. Have you been outside of Iowa since 1975? ______Yes ______No

If Yes:
- a. List states____
- b. When (year)________________________________
- c. Length of stay (mos./yrs.)__________________
- d. If in prison, how long________ What states________________

15. HAVE YOU RECEIVED BLOOD/BLOOD PRODUCTS SINCE 1975? ______Yes ______No

If Yes:
- a. When____________________________
- b. Kinds____________________________
- c. Amount___________________________

16. SYMPTOMS AND SIGNS OF AIDS:

	Yes	No	Onset
a. Unexplained, persistent fatigue	____	____	__________
b. Unexplained fever, shaking, chills, or drenching night sweats lasting longer than several weeks	____	____	__________
c. Unexplained weight loss greater than 10 pounds	____	____	__________
d. Unexplained swollen glands lasting longer than two weeks	____	____	__________
e. Unexplained skin changes, especially purplish blotches or bumps, or bruises that do not disappear	____	____	__________
f. Persistent white spots or blemishes in the mouth	____	____	__________
g. Persistent diarrhea	____	____	__________
h. Persistent dry cough, not associated with URI	____	____	__________

17. HISTORY OF HEPATITIS: ______Yes ______No

If Yes:
- a. What type________________________
- b. When_____________________________
- c. _____Hospitalized or ______Outpatient

18. HISTORY OF STD: ______Yes ______No

If Yes: a) Warts____; b) Herpes_____; c) Gonorrhea_____; d) Chlamydia_____
e) Nonspecific vaginitis/urethritis_____; f) Other ______________

19. PREVIOUS TEST(S) FOR AIDS VIRUS: ______Yes ______No

If Yes:
- a. Where____________________________
- b. Results__________________________

20. HIV ANTIBODY TEST: Date Drawn:______________ Results__________________

21. WBC__________ mm^3
Differential: ______% segs.; ______% bands; %______eos.; ______% basos.;
______% lymphs.; ______% monos.; ______% morph.

Completed by______________________________________ ________________________
Signature/Title Date Completed

12/18/86

MARYLAND DIVISION OF CORRECTIONS
AIDS RELATED SYNDROME QUESTIONNAIRE

Appendix 2 DCR 130-11

Inmate Name____________________Number_______Date_______Interviewer________________

DIRECTIONS: This form is to be filled out on each new admitted inmate to the Division of Correction. This form is also to be used at sick call when the health care provider suspects the possibility of AIDS.

ask all questiions verbatum

In the last month, have you had any of the following problems or symptoms?

A. How about ( )? Did you have that at any time in the past month?

FOR EACH "YES" ASK B AND C:
B. When did it begin?

C. Do you still have that?

	A. HAD IN LAST MONTH		B. WHEN BEGAN	C. HAVE	
PROBLEM OR SYMPTOM	NO	Yes	MONTH YEAR	NO	YES
(1) Persistent shortness of breath for at least 2 weeks................	1	2	---19----	1	2
(2) A new or unusual kind of dry cough that lasted 2 weeks or longer......	1	2	---19----	1	2
(3) Thrush, Candida or white patches in your mouth or throat for at least 2 weeks	1	2	---19----	1	2
(4) An unintentional weight loss of at least 10 pounds (unrelated to dieting.....	1	2	---19----	1	2
(5) Diarrhea for at least 2 weeks................	1	2	---19----	1	2
(6) Persistent or recurring fever higher than 100 for at least 2 weeks................	1	2	---19----	1	2
(7) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 2 weeks..	1	2	---19----	1	2
(8) Sweating at night for at least 2 weeks...........	1	2	---19----	1	2

Appendix 3 DCR 130-11

AIDS RELATED DISEASES EXAMINATIONS

A. General

1. Height
2. Weight

Check for presence of:

B. Skin

1. Patechiae (for thrombocytopenia)
2. Hyperpigmented nodular lesions (Kaposi's sarcoma)

C. ENT

1. Oral/Pharyngeal candidiasis
2. Herpetic lesions

D. Eyes

1. Exudates (CMV or Toxoplasmosis)

E. Abdomen

1. Hepatomegaly or Splenomegaly

F. Anal/Rectal

1. Herpetic lesions (chronic, spreading)

G. Extremities

1. New edema (nephrotic syndrome

LAB VALUES

RPR

Hep B-Surface Antibody

Hep B Core Antibody

Chest X-ray

HTLV III

Anergy Skin Testing

CBC

Blood Chemistry

T Cells

Serum Globulin

APPENDIX G

Examples of Correctional AIDS Policies

1776

GEORGIA DEPARTMENT OF CORRECTIONS
Floyd Veterans Memorial Building
Room 756 - East Tower
Atlanta, Georgia 30334

David C. Evans
Commissioner

May 8, 1987

CLINICAL UPDATE NO. 87.04

TO: Health Authorities and Medical Personnel
State Correctional Institutions

FROM: William A. Hopkins, M.D.
Medical Director, Health Services

William A Hopkins

RE: Guidelines for HIV Testing

It is apparent that some further guidelines are necessary in regard to testing inmates and health care personnel for possible contamination of the HIV virus. These guidelines are not meant to be hard and fast, and must be upon the decision of the Medical Director in each case. Public Law HB-92, passed by the 1987 General Assembly states that if any inmate in the custody, or in the process of being taken into custody, injures law enforcement in a manner as to present a possible threat of transmission of a communicable disease, a medical examination may be made to determine whether the inmate is positive with the virus.

If the inmate refuses, a petition can be filed in Superior Court for an order authorizing such procedures. It is obvious that many incidents may occur in which one party or the other may feel that they could possibly have been exposed to the virus while in contact with an inmate. We recommend under the following conditions that the inmate be tested for the possibility of having AIDS:

1. An injury with possible contamination by instruments, such as knives, needles, dental equipment, etc. This, of course, would be a penetrating wound that has occurred after the instrument has been used on an inmate.

2. Exposure of body fluids by means that might bring about an exchange, such as contact with mucus membranes, or open wounds. Mucus membranes are considered the eye, mouth, urethrae and rectum. This would include those persons who were exposed to feces or urine of inmates. The exposure would not be simply on the body or clothes, but would have to contact one of the above mentioned areas in order to be considered an exposure.

3. In the case of rape, the inmate must be tested immediately. If negative, he would have a repeat test in six months. It is recommended that the victim also be tested. This test should occur as soon as possible after the incident. If the victim is negative, they should be tested

again in 3 months, and then 6 months. If the inmate is negative at 6 months, it would not be necessary for the victim to be tested at the end of the year. However, if for some reason the status of the inmate is unknown after the 6 month period, the victim should be tested at the end of the year after the incident.

4. In the case of personnel, the Department will offer to provide the testing for them. If the individual decides to get the test through their own private facilities, then we should insist that they sign a release from the Department stating that we had offered the test to them and strongly recommended it be done.

5. In every case, both the victim and the perpetrator should be thoroughly counseled as to how to handle the situation and receive good support from the medical staff to help them through this period of time. If either party is positive, then of course counseling would be necessary as to the prevention of the spread of the disease.

6. For the present time, in cases where there may be assaults made from one inmate to another, the following is recommended. In documented rape situations, both parties should be tested and counseled as to the results of the test. If they are negative, both individuals need to be tested again in 6 months to a year.

These are meant to be guidelines and the final decision is a matter of medical judgement. If there is a conflict between the decision the Medical Director and the wishes of the Institutional Administration, this would be referred to our office for consideration and recommendations.

WAH:lwg
cc: Ronald E. Lane, Deputy Commissioner, Industrial Operations/Programs
Walter Zant, Deputy Commissioner, Division of Facilities

PROTOCOL FOR THE PREVENTION AND MANAGEMENT OF HIV INFECTION IN THE MICHIGAN DEPARTMENT OF CORRECTIONS

I. OBJECTIVE, APPLICATION AND INFORMATION

This document is to have department-wide application. It is issued pursuant to PD-DWA-42.07, "Control of Communicable Diseases", which directs the Bureau of Health Care Services (BHCS) to develop procedures addressing the prevention, control, and treatment of several infectious diseases, specifically including the Acquired Immune Deficiency Syndrome (AIDS). AIDS is caused by what is now called the Human Immunodeficiency Virus (HIV). This virus has also been called the human T-cell lymphotropic virus (HTLV-III), the lymphadenopathy-associated virus (LAV) and the AIDS-associated retrovirus (ARV). This document will refer to this virus as the HIV, and will address HIV infection in general. It is issued as a protocol, rather than as a formal operating procedure, to allow the Department to respond rapidly to new information, to changes in public health policy, and to applicable legislation in this complex area. It does not address treatment, and does not contain education material beyond definitions of terminology and other essentials.

Once HIV infection occurs, the individual is considered, for public health purposes, to be infected and capable of transmitting the virus to others by specific mechanisms, for life. HIV infection may severely damage the immune system, allowing usually rare cancers to occur and/or allowing usually harmless microorganisms to cause life threatening infections (either of these constitutes AIDS), or it may cause less serious illness (sometimes called AIDS-related condition or complex, "ARC"), or it may cause no detectable illness at all. It is roughly estimated that for every case of AIDS in the USA, there are ten cases of "ARC" (less serious illness) and as many as one hundred apparently healthy HIV infected persons. Several years may intervene between HIV infection and the appearance of illness; if it occurs, illness may or may not progress to a more serious category. If the HIV damages the immune system severely enough to cause AIDS, the cancer or life-threatening infections, though usually treatable, continue to occur or recur, and adults with AIDS usually die within several years.

All HIV infected persons, regardless of whether or not they are ill, can potentially transmit the virus, not by casual contact, but by specific behaviors or mechanisms. These include sharing of blood or blood-contaminated sharp instruments (usually needles), sharing of semen and possibly other body fluids (usually during sexual activity), and transmission through the birth process, to infants. In the USA, homosexual or bisexual men and IV drug users have accounted for about 90% of AIDS cases. Over the past several years, a constant proportion of AIDS cases has occurred among persons with no known risk factors, a category which also includes persons who could not or would not be interviewed regarding risk factors. Concerns about airborne, waterborne, insect vector and casual contact spread have not been substantiated, since such spread would result in an increase in the "no risk factor" category, which has not occurred. Moreover, careful studies of health care workers who have cared for patients with AIDS, and of household contacts of patients with AIDS, have disclosed no evidence of spread by casual contact.

At present, no test which actually detects the HIV in the body or blood is widely available. However, nearly all HIV infected persons eventually react to infection by producing specific blood proteins called antibodies. These antibodies react with parts of the virus and can be detected in the blood. A very reliable series of tests for HIV antibodies is widely available. Antibody-positive persons are considered infected with the HIV, and, therefore, are also considered potentially infectious if they engage in the behaviors mentioned above.

II. DEVELOPMENT OF A DATA BASE

The spread of HIV infection among prisoners requires the presence of infected prisoners and requires specific high-risk behaviors involving infected and uninfected prisoners. For practical purposes, this means IV drug use with shared injection equipment or unsafe male homosexual activity. Though these activities do occur in prison, their frequency is not known, nor is the prevalence of HIV infection among MDOC prisoners known. Data on high-risk behaviors and on the prevalence of infection are potentially useful in determining if changes in prisoner management are needed, in assessing the impact of educational programs, and in predicting costs and other impact of management options.

The BHCS will work with the Michigan Department of Public Health to study, on an ongoing basis, the prevalence of HIV infection in newly committed MDOC prisoners. This will consist of anonymous testing for HIV antibodies in blood specimens already being obtained for Reception Center processing in a sample of newly committed prisoners. Such specimens will be tested only after completion of tests for which the blood was actually drawn and after removal of identifying information, so that no additional blood will be drawn and no HIV antibody result will be linked to any individual prisoner. This study will be conducted for an appropriate period and repeated at appropriate intervals to yield reliable data on the prevalence of HIV antibody positivity among newly committed prisoners. Data collection shall begin within 60 days and be reported to the Director within six months.

The BHCS will consult and work with the Michigan Department of Public Health (MDPH) and with academic institutions with expertise in public health to design methods to study the frequency of high-risk behaviors such as IV needle sharing and unsafe male homosexual activity among prisoners, as well as to study prisoners' knowledge of mechanisms of HIV spread.

The Deputy Director for the BHCS will report to the MDPH on a quarterly basis information on HIV infection in MDOC prisoners, including numbers of cases of AIDS, other HIV-related illness, and apparently healthy HIV infection. The format of such reports will be jointly developed by the BHCS and the MDPH.

III. SCREENING, COUNSELING, AND EDUCATION

No treatment which eradicates HIV infection is available, no vaccine to prevent infection with HIV is available, and infected persons usually are not ill and do not have any distinguishing characteristics. Thus education, particularly of members of high- risk groups, regarding how to avoid infection is the best practical and available tool to reduce and eliminate HIV-related disease. As the average sentence for MDOC prisoners is less than three years, effective educational efforts could have benefit far beyond incarceration.

The Public Health Service now recommends voluntary, informed HIV antibody testing of high-risk group members as an adjunct to counseling of such individuals. The MDOC policy regarding HIV antibody testing is as follows. There will be no mass testing of employees or prisoners (other than the periodic anonymous Reception Center sampling described above). The HIV antibody test will be ordered only by a physician, or by a physician assistant with specific delegated authority from the supervising physician. The test will be performed at the request of the prisoner, or may be suggested by the physician/physician assistant based upon the prisoner's membership in a risk group, possible exposure, or symptoms or signs suggestive of HIV infection. No more than one test per six month period will be done solely at the request of the prisoner, but no limit is placed on the frequency of clinically appropriate tests. In all cases, pre-test and post-test counseling must be done (the BHCS will distribute appropriate up-to-date written material to be used in counseling), and the counseling must be documented in the health record. The prisoner's consent to testing must also be documented in the health record by the physician/physician assistant.

Educational efforts must utilize effective methods and materials. The BHCS will work with the Training Division periodically to evaluate and update audiovisual and written teaching materials regarding HIV infection suitable for institutional and field service staff, incorporating such material into new employee training programs and into current employee retraining and update programs. Audiovisual and written materials suitable for prisoners shall similarly be evaluated and updated. Materials prepared outside the MDOC may have more credibility than those prepared by the Department. Material for prisoners must explicitly address and emphasize the danger of IV drug use with shared injection equipment and of unsafe sexual activity. Materials identified by this cooperative effort will be shared with law enforcement agencies which operate correctional facilities via the Office of Facility Services, and interested groups of law enforcement personnel.

Reception Center processing is one opportunity to use existing Department structure to expose incoming prisoners to educational material regarding their health. The BHCS will work with Bureau of Correctional Facilities Reception Center staff to expose each incoming prisoner to written, and if possible, audiovisual educational material developed by the BHCS/Training Division cooperative effort. Once prisoners have completed Reception Center processing and are transferred to institutions, this education program will be repeated during classification orientation programs. The BHCS will revise Reception Center health screening procedures and forms to improve the likelihood that prisoners with, or at risk of, HIV infection are identified, counseled and offered voluntary informed HIV antibody testing (as outlined above), and that those who have HIV-related illness are promptly identified and treated.

Because one risk group, IV drug users, is overrepresented in correctional facilities, the Department has a unique opportunity to inform this group. The concern about HIV infection, as well as the availability of adjuncts to abstinence such as an oral, long acting, non-addicting narcotic antagonist, provide an opportunity to develop effective treatment programs for some narcotic users, especially during correction center residence and parole. The Bureau of Field Services (BFS), BHCS and other appropriate Department entities will work with the MDPH to explore options, including funding, for utilization of such treatment and counseling programs.

Each institution will assign an employee, selected by the medical director and preferably a member of the medical staff, to work with the institution Training Committee as a resource person for AIDS information at that facility. This individual will be responsible for being well informed regarding the epidemiology of HIV infection, regarding MDOC policy in this area, and for involving the Training Committee in educational activities. Appropriate activities for the resource person and the Training Committee include, where applicable, conducting inservice programs for health care, transportation, laundry, food service and other concerned staff, addressing the Warden's Forum and other prisoner organizations, providing informational material for the institution newspaper, posting informational posters, and other such activities utilizing the educational materials developed by the BHCS/Training Division cooperative effort. To ensure that an active educational program is ongoing at each facility, and that particularly effective or useful education activities are shared throughout the Department, this resource person will report quarterly to the Deputy Director for BHCS, outlining activities of the previous three months.

The BHCS will organize and conduct, in cooperation with the Training Division, ongoing inservice education programs for health care staff to ensure that such staff in all disciplines are well informed regarding prevention of HIV infection and detection and treatment of those infected.

The Bureau of Field Services will work with the training Division and the BHCS to disseminate rapidly and efficiently the educational material developed for staff to BFS personnel, particularly those in urban centers, where supervision of significant numbers of offenders in corrections centers and on parole will occur. BFS staff will also be given this information as part of training update programs.

IV. GENERAL PRECAUTIONS TO PREVENT TRANSMISSION OF INFECTION

Prudent practices and precautions to prevent the transmission of blood-borne infections such as HIV should always be usual and routine for staff and prisoners. Because only a small fraction of those infected with the HIV know of the infection or are known to others as infected, or are ill, it is more rational to take precautions all of the time than to construct and rely upon intricate notification or identification procedures regarding those who are known to be infected.

Prisoners exhibiting violent or threatening behavior should be presumed to be infected, and should be managed so as to minimize the potential for exposure to blood. Sharp items possessed by or in contact with prisoners or any person should be handled with extraordinary care to prevent accidental injuries. Hands or other body parts should be washed immediately and thoroughly if in contact with blood. Gloves should be worn before handling or cleaning up blood or other body fluids, either directly or on clothing or other items. Though mouth to mouth breathing has not been implicated in transmission of the HIV, it is prudent to have CPR masks (and gloves) immediately available in all areas serving prisoners, and carried by escort staff in areas where such supplies are not immediately available.

Existing institutional laundry and dishwashing procedures are adequate to decontaminate linens, clothing, dishes, trays and other reusable meal utensils. When cleaning environmental surfaces, commonly used housekeeping procedures are adequate. Surfaces exposed to blood or other body fluids should be cleaned using gloves, soap and water or household detergent and then wiped with an EPA-approved disinfectant or a freshly prepared solution of houshold bleach (one half cup of bleach per gallon of water is adequate). Plastic bags may be used to transport grossly contaminated items for disposal as solid waste, and soluble (dissolvable) bags shall be used to transport grossly contaminated laundry and placed directly into the washer.

Blood and secretion (body fluid) precautions will, therefore, be a routine, rather than an exceptional practice. In unusual circumstances, transport of prisoners known to have bleeding, draining wounds or sores, infectious diarrhea or infectious respiratory illness will merit a reminder regarding blood and secretion precautions or require specific additional infection control precautions on the part of escort staff. Each institution medical director will review and, if necessary, implement procedures to ensure that escort personnel (and personnel at the receiving facility) are notified of the need for such specific precautions. Unless necessary for health care, this does NOT require or authorize disclosure of the specific diagnosis. The specific precautions needed (for example, blood and secretion for hepatitis B or hepatitis non-A non-B or HIV infection, respiratory with masks for pulmonary tuberculosis, mumps or meningococcal infection, etc.) should, however, be explicitly described.

V. MANAGEMENT OF BODY FLUID EXPOSURE INCIDENTS

If a cut, needlestick or other puncture, or mucous membrane (splash to the eye or mouth) exposure to blood or other body fluid occurs, the exposed area should, if possible, be promptly cleansed. A physician should be consulted concerning the likelihood of HIV infection (and, if applicable, the likelihood of other blood-borne infectious diseases such as syphilis and hepatitis B) in the source of the blood or body fluid (if known) and concerning the significance of the exposure. Appropriate guidelines for evaluation of the source and exposed person are as follows. If a physician judges that the exposure was significant, and if the source person is known, that source person should be asked to consent to appropriate epidemiologic, clinical and serological (HIV antibody and other appropriate tests) evaluation. If the source person declines evaluation or has AIDS or other evidence of HIV infection such as the antibody, the exposed person should be evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure. If seronegative, she/he should be retested after six weeks and on a periodic basis thereafter (e.g., three, six and twelve months after exposure) to determine if transmission has occurred. During this follow-up period, especially the first six to twelve weeks, when most newly infected persons are expected to seroconvert to HIV antibody-positive status, the exposed person should receive counseling about infection and should take precautions to prevent transmission of the HIV. If the source person is unknown, decisions regarding follow-up should be individualized based on the type of exposure and the likelihood that the source person was infected.

All instances of such exposure shall be promptly reported to the institution head and to the institution medical director (or in non-institution settings, to the office of the Deputy Director for BHCS). The medical director will implement the evaluation and counseling outlined above for prisoners, and employees will be referred to the occupational physician. Each medical director will contact the institution's occupational physician to ensure that both understand and agree on the appropriate management of employees who have had body fluid exposure. Necessary medical information regarding the source of such exposures may be shared with the occupational physician by the medical director, but need not and should not include identifying information.

VI. EMPLOYEES AND HIV INFECTION

HIV infection in an employee shall not itself be a consideration in appointment, promotion, or other condition of employment, except that employees with HIV infection whose duties involve invasive procedures (e.g., surgery, dental surgery, phlebotomy) will be required to take appropriate extra precautions when performing such procedures, and may be restricted from performing certain procedures. A coexistent illness or condition may be a relevant consideration in appointment, promotion or other condition of employment, but only on its own merits.

It is the policy of the MDOC that employees shall not be excused from working with or caring for HIV infected prisoners or parolees, or from working with HIV infected employees, based solely on their own request. Employees who believe that they are at high risk of HIV infection because of their own health status, or who have concern because of pregnancy, should discuss their work responsibilities with their personal physician. If the physician judges the assignment to be hazardous to the employee, this information should be communicated in writing for appropriate action on a case by case basis.

VII. HIV INFECTION IN PRISONERS

All cases of AIDS will be reported as required by law to the Michigan Department of Public Health through the local health department. All cases of HIV infection in prisoners, regardless of the presence of illness (including apparently healthy antibody-positivity, AIDS, and other HIV-related illness regardless of clinical classification) will be reported to the Deputy Director in charge of the Bureau of Health Care Services within two business days. This information is to be considered confidential health record information. The presence of HIV infection in a prisoner does not alone constitute a threat to the safety and security of the prisoner or the institution, and no disclosure or request for disclosure of this specific information shall be made based on such a presumption alone. Limited disclosure (e.g. that a particular prisoner has an unspecified blood-borne/sexually transmitted disease agent) to the institution head for the purpose of managing behavior is discussed elsewhere in this protocol. Disclosure to custody personnel for use in program classification and disclosure on health clearance forms for transfer among MDOC institutions shall be similarly limited and not name the specific disease or agent. When the health clearance form is used for informational purposes and is not accompanied by the health record (such as when it accompanies the prisoner to court, or is used to provide information to the Bureau of Field Services staff to assist in determining Community Program eligibility), more explicit information will be provided.

Occasionally a report that a convicted person may have HIV infection or related illness is appropriately included in a pre-sentence report. BFS staff who elect to include such data in a pre-sentence report shall carefully consider and explicitly document the source of such information. MDOC institution staff shall treat this as confidential health record information.

If an HIV-infected prisoner has contacts who are clearly at risk, that prisoner should be informed of the importance of notifying those contacts who are known. The notification should be done by the prisoner, or by designated Bureau of Health Care Services staff with the written consent of the prisoner. If the prisoner refuses to notify, or to permit designated Bureau of Health Care Services staff to notify contacts who are clearly at risk, Central Office Bureau of Health Care Services staff shall consult with the appropriate health officer regarding options for proper notification of such contacts.

Housing assignments for prisoners with HIV infection will be consistent with their security classification and medical needs. HIV-infected prisoners requiring intensive hospital care will be admitted, as soon as circumstances permit, to the Department of Corrections Secure Unit. Infected prisoners requiring less intensive hospital care will be admitted to the Duane L. Waters Hospital at the State Prison of Southern Michigan. HIV-infected prisoners who do not require inpatient care will be eligible for general population housing at any institution which can meet their health care and security needs, and will also be eligible for any programming and work assignment which their health and behavior allows.

It is the goal of the MDOC to reduce the frequency of prisoner behaviors which might transmit the HIV, both by education regarding the health hazards of such behaviors, and by surveillance and appropriate supervision. Occasionally, despite counseling by health care staff and other educational efforts, a prisoner will continue behaviors which may transmit to others or to himself or herself a blood-borne/sexually transmittable infectious agent such as the HIV, the hepatitis B virus, or other agent. This behavior may occur due to a lack of understanding or lack of capacity to understand the hazard, or a lack of concern for his or her own health, or that of others; but it represents a potential health hazard.

The medical director and the institution head will consult promptly when either party discovers an infected prisoner or one engaged in high-risk behavior. The purpose of such consultation is outlined below. The medical director shall not disclose the specific diagnosis or infectious agent. Rather, the focus shall be on behaviors which need to be eliminated. Utilizing misconduct findings, critical incident reports and other appropriate sources, each institution head will assemble a list of prisoners whose behavior (intimate sexual activity, substance abuse in which IV-needles may be involved, or repeated assaultiveness) might transmit blood-borne/sexually transmitted agents. This will permit such behavior to receive special attention, particularly if review of the health records of such prisoners by the medical director reveals evidence of infection. It will also permit such prisoners to be offered appropriate counselling and health screening. Concurrently, each institution medical director will maintain a secure list of prisoners at that facility who are known to be carriers of infectious agents, with special attention to blood-borne/sexually transmitted agents such as the HIV and the hepatitis B virus. This will permit review of the behavior of such prisoners by both the institution head and the medical director.

Each institution head and medical director shall meet at least monthly to review the behavior of prisoners known to be infected, utilizing institution files, critical incident reports (and rarely health record data regarding behavior, which may not be the sole basis for disciplinary action) so that infected prisoners who are engaged in high-risk behaviors will have the behavior addressed. Increased surveillance of prisoners who are merely infected, but not known to be engaged in high-risk behavior, while potentially useful, carries the hazard of subjecting such prisoners to de facto widespread disclosure of their infection. Therefore, infected prisoners who are not known to be engaged in such behavior will not be subject to special or increased surveillance other than the monthly record review just described.

The second task to be accomplished is that of reviewing the behavior of all prisoners believed to be engaging in high-risk behaviors. If such identified prisoners, even after counseling, continue to engage in high risk-behavior, the institution head will promptly initiate such action as is appropriate to remove the opportunity for such behavior. Options for action will vary depending upon the nature of the behavior and how well it is established that the behavior is occurring, but might include change in housing, programming, security classification or level of surveillance or transfer to a facility which can provide the necessary supervision. The least restrictive, but effective, action shall be taken, and the decision shall be re-evaluated every three months at the facility where the prisoner is housed. Since the behavior is the focus of such action, no further disclosure of health information is to occur.

PREPARED BY:

THE MDOC TASK FORCE ON AIDS

CRAIG HUTCHINSON, M.D.

REVISED OCTOBER 1986

DIVISION OF CORRECTION REGULATION

STATE OF MARYLAND

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

DCR NO. 130-11

DATE September 28, 1987 (Draft)

SUBJECT: HEALTH SERVICES

TITLE: Acquired Immunodeficiency Syndrome (AIDS)

I. Reference:
- A. Morbidity and Mortality Weekly Report (MMWR) June 28, 1985.
- B. MMWR, November 5, 1982.
- C. MMWR, September 27, 1985.
- D. MMWR, March 28, 1986.
- E. Governor's AIDS Task Force Report.
- F. Journal of the American Medical Association (JAMA), April, 1986.

II. Applicable to: All Employees and Inmates.

III. Purpose: The purpose of this policy and procedure is to reduce the risk of transmitting the etiological viral agent of AIDS in the Maryland Correctional System by:

A. Making available to health care providers a description of AIDS including a case definition, risk factors and some clinical features.

B. Establishing procedures for the identification and evaluation of persons suspected of having AIDS and AIDS related diseases.

C. Implementing educational programs for staff and inmates.

D. Implementing policies governing the management of individuals suspected of having AIDS.

IV. Definitions:

A. AIDS: a serious communicable disease which alters the body's immune system. Like patients receiving immunosuppressive therapy, AIDS patients are susceptible to a number of opportunistic conditions.

The Centers for Disease Control has defined AIDS as "a reliably diagnosed disease that is at least moderately indicative of an underlying cellular immunodeficiency or of increased susceptibility to that disease." Presence of HTLV-III antibody was included in the definition of AIDS-related diseases in June 1985 (MMWR, June 28, 1985). The conditions accepted by the CDC as evidence of AIDS and the appropriate diagnostic procedures for these conditions are listed in Attachment 1.

B. Opportunistic Disease: diseases which occur only in persons with serious immune deficiency. Prior to the development of an opportunistic disease, AIDS patients may develop prodromal signs and symptoms including: fever, night sweats, chronic lymphadenopathy, thrush, unexplained weight loss, chronic or recurrent diarrhea, non-productive cough, shortness of breath, and lymphopenia. Other non-specific symptoms such as malaise, usually occur but are not informative by themselves. (see Appendix 6)

V. Policy: It is the policy of the Division of Correction that all inmates and employees shall be provided appropriate education and training to improve the management of AIDS-related diseases.

VI. Procedure:

A. Education

1. During the reception process at RDCC and MCIW all inmates shall attend group education presentations during the orientation process. The education process shall include a verbal instruction of AIDS related problems and how to protect oneself from becoming infected. Inmates shall be provided with written material about AIDS including a booklet on HTLV-III test. A film developed by the Division of Correction and Johns Hopkins Medical Institution shall be shown.

2. Additional services shall be provided to all inmates known to have serologic evidence of infection with the AIDS virus, inmates with AIDS-related complex (ARC), and inmates with AIDS. This education at a minimum shall include instructions in responsible behavior given the inmate's medical status.

3. Within the Pre-Release System educational group meetings for inmates who will be going home for family leave and/or working in the community shall be held bi-weekly. No inmates may go home for family leave or work in the community without having attended an AIDS educational session.

4. Employees shall be provided AIDS education by the Correctional Training Academy during institutional orientation, and during routine in-service training.

B. Procedures and Evaluations

The procedure for identification and evaluation of inmates with suspected AIDS are described below for new inmates seen at the Reception, Diagnostic and Classification Center (MRDCC) and the Maryland Correctional Institution for Women (MCIW), as well as for those inmates currently in the correctional system as follows:

1. New Inmates:

New inmates shall be evaluated at the MRDCC and MCIW. The following items shall supplement the pre-existing medical evaluation procedures. This screen shall be part of the medical screening for inmates returning from the street on work release or family leave or other types of leave:

a. History - Specific standardized questions are asked to obtain a history of fever, thrush, night sweat, weight loss, diarrhea, and recent onset of a non-productive cough. The standardized questionnaire is attached to the intake physical examination for and is administered by a health care provider (Appendix 2).

b. Physical examination - Protocols are designed to obtain a more careful oropharyngeal exam, lymph node search and anal examination. Items to be noted are given in Appendix 3. Health care providers will be given regular in-service training to standardize the physical examination procedures.

c. Epidemiological planning purposes - The antibody test may be used for epidemiological purposes. As indicated, groups may be asked to allow testing for the antibody to find the specific prevalence patterns within incarcerated populations. These individuals shall not be given the option of knowing their antibody status. A blinding procedure has been set up and shall be maintained so that no correctional laboratory personnel shall know the specific antibody status of any individual screened for epidemiological purposes. Bloods used for these purposes are sent to the laboratory after consent is obtained from the inmate, labeled only with a code number. The demographic information available such as age, race, date of incarceration, and possible previous incarceration are put on the computer tapes and sent to the lab. The lab then tests the blood, and matches the test results to the demographic information by the code number. No names are included either on the blood tube or computer tape. No laboratory personnel shall be given the individual test results. (In this way privacy of inmates as well as job security of laboratory and correctional personnel is safeguarded.)

2. Inmates in the System

Inmates already in the system will usually come to the attention of the medical providers through "sick call." Inmates complaining of symptoms of AIDS or any symptoms indicative of one of the opportunistic conditions should be evaluated as soon as possible. Inmates with signs and symptoms of opportunistic infections shall be evaluated quickly. Failure to do so may result in progress of infection to a stage at which it cannot be adequately treated. Two or more clinical diagnosed symptoms (see Appendix 4) should be presented before laboratory workup is obtained.

A workup for AIDS related complaints shall include:

a. History - Questionnaire about recent health status should be performed (Appendix 2). Questioning about AIDS risk factor may be of interest but is not of assistance in the management of these patients.

b. Physical examiantion - The physical examination shall include weight to document weight loss, careful eye examination for exudates (CMV or toxoplasmosis, a careful examination of swollen lymph nodes or spleen, and a skin examination for new hyperpigmented nodular lesions (Kaposi's Sarcoma), petechiae (thrombocytpenia), new edema (nephrotic syndrome), and progressive genital/anal herpes (suspicious herpetic lesions are those which persist or progress coalescense.) The examination will be indicated on a copy of Appendix 3.

c. Laboratory - Blood should be drawn for the following test: CBC with differential white blood cell count and platlets, RPR chemistries, and hepatitis B screen. These patients should also have a chest x-ray. HIV antibody test is done only for those individuals which have two or more signs or symptoms. The test is only done with proper consent and counseling by the medical provider.

C. Reporting and Management of Inmates With Suspected or Documented AIDS-Related Diseases

All cases which have been worked up for the clinical workup for AIDS should be documented on appendices 2, 3 and 4. Copies of these should be kept in the chart with the other medical information and a copy should be sent to Central Headquarters. If the patient is found to have ARC or AIDS, there should be an immediate phone call to the Chief Medical Officer from the Medical Director for the region. If a case of AIDS is diagnosed in an outlying hospital, for example the University of Maryland, the regional Medical Director that referred the case is responsible for obtaining as much information as possible to complete the report forms and to send those report forms in as well as to call the verbal report to the Chief Medical Officer. At the time of verbal reporting over the telephone, the Chief Medical Officer will discuss management and housing of the AIDS case or the ARC individual with the Medical Director for the region. It is not expected that most of the individuals worked up for AIDS related diseases will have been done so purely because of clinical indications. There are many individuals who come into the system and claim they have AIDS or AIDS infection. Because of the resulting confusion an AIDS workup is often indicated for these individuals. When the clinical workup is completed, if there are less than two clinical symptoms, the laboratory workup need not proceed. The person is then counseled. It is explained to that person that they do not have AIDS and that no further workup is necessary. As with all AIDS related disease reporting, Appendices 2, 3 and 4 are filled out for this individual and the report is sent out to DOC Headquarters.

1. Any change of status of any inmate shall be reported by telephone to the Chief Medical Officer and the Director of Health and Mental Health Services the same day.

2. This report shall be followed by written reports consisting of appendices 1 - 4 marked appropriately as well as any other written material necessary to explain the clinical history and status of the inmate.

3. No inmate who is in categories 2 and 4 shall be transferred to any other institution without the approval of the Commissioner

4. All press inquiries shall be referred to the DOC Headquarters Public Information Officer.

D. Management of Inmates - Inmates shall be medically managed as one of five categories:

1. General Population - there is not now and never has been any suspicion of an AIDS- related disease.

2. Possible AIDS-related diseases - there are at least two reasons beyond risk factor status to suspect AIDS-related diseases. The reason to suspect AIDS-related diseases are listed on the appendixes. These individuals shall be cohorted at the regional infirmary and worked up promptly for AIDS-related diseases. (Copies of Appendices 1-4 will be filled out to indicate this patient's clinical status and placed in the medical chart as well as sent to DOC headquarters.)

3. AIDS Related Complex (ARC) - patients with ARC defined in Appendix 4 shall be medically monitored for signs of opportunistic diseases as listed in Appendix 1 (Methods of Diagnosing Infectious Complications in AIDS Patients.) Medical monitoring ARC patients can be accomplished in the regional infirmary and does not require transfer to Baltimore. There shall be documentation of medical evaluation of progress of diseases at least weekly. If the symptoms resolve, the patient can be followed from the general population, with documented followup evaluations monthly.

4. AIDS - inmates with AIDS as diagnosed by the methods detailed in Appendix 1 shall be medically transferred to the Maryland Penitentiary hospital (females go to MCIW) on the authority of the Chief Medical Officer and regional Medical Director without reclassification action. The privileges allowed to them shall be consistent with the privileges allowed other inmates there, limited only by their individual medical needs.

5. AIDS - related diseases followup - those suspected AIDS patients who have been worked up and found not to have any of the AIDS related diseases shall be released back into the general population with regular followup to the medical clinic (at least every 6 months.)

E. Infection Control

Infection control procedures shall be observed as decribed in Appendix 5 for infected individuals. More recent data has been published on risks of infection to health care workers (MMWR vol 34, no. 38, September 27, 1985.) All available data suggest that exposure during normal daily health care carries far less risk of infection than the activity carries for infection to hepatitis B.

F. Evaluation Protocol

This evaluation protocol shall be evaluated periodically and updated in light of accumulating new information.

G. Supporting institutional directives are not indicated to implement and comply with this DCR.

VII. Attachments: Appendix 1, Diagnostic Criteria for AIDS
Appendix 2, AIDS Related Syndrome Questionnaire
Appendix 3, AIDS Related Diseases Examinations
Appendix 4, AIDS Related Complex Criteria
Appendix 5, Acquired Immune Deficiency Syndorme (AIDS)
Appendix 6, Recent Statistical Information
Appendix 7, Management Audit Form

VIII. Rescissions: None

Arnold J. Hopkins, Commissioner

Distribution:
A
L
S - All Medical Contract Administrators

Appendix 1 DCR NO 130-11

DIAGNOSTIC CRITERIA FOR AIDS

1.0 For reporting purposes, a case of AIDS is defined by the diagnosis of one or more of the following opportunistic "indicative" diseases.

1.1 The following indicative diseases do not require an HIV antibody test to meet the criteria for the AIDS case definition:
- 1.11 CANDIDIASIS of esophagus, trachea, bronchi, or lungs.
- 1.12 CRYPTOCOCCOSIS, extrapulmonary.
- 1.13 CRYPTOSPORIDIOSIS with diarrhea persisting greater than 1 month.
- 1.14 CYTOMEGALOVIRUS disease of an internal organ other than liver, spleen, or lymph nodes, in a patient greater tnan 1 month of age.
- 1.15 HERPES SIMPLEX VIRUS infection causing a mucocutaneous ulcer that persists greater than 1 month, or bronchitis, pneumontis, or esophagitis for any duration in a patient greater than 1 month of age.
- 1.16 KAPOSI'S SARCOMA in a patient less than 60 years of age.
- 1.17 LYMPHOMA OF THE BRAIN (PRIMARY) in a patient less than 60 years of age.
- 1.18 LYMPHOID INTERSTITIAL PNEUMONIA and/or PULMONARY LYMPHOID HYPERPLASIA (LIP/PLH COMPLEX) in a patient less than 13 years of age.
- 1.19 MYCOBACTERIUM AVIUM COMPLEX or M. KANSASII disease at a site other than lungs or lymph nodes.
- 1.20 PNEUMOCYSTIS CARINII PNEUMONIA.
- 1.22 PROGRESSIVE MULTIFOCAL LEUKOENCEPALOPATHY.
- 1.23 TOXOPLASMOSIS of the brain in a patient greater than 1 month of age.

1.2 The following diseases must be accompained by a positive HIV antibody test:
- 1.21 COCCICIOICOMYYCOSIS, extrapulmonary or disseminated.
- 1.22 HIV ENCEPALOPATHY ("AIDS DEMENTIA COMPLEX") see part 2.4 of this document.
- 1.23 HISTOPLASMOSIS, extrapulmonary or disseminated.
- 1.24 ISOSPORIASIS with diarrhea persisting greater than 1 month.
- 1.25 KAPOSI'S SARCOMA at any age.
- 1.26 LYMPHOMA OF THE BRAIN (PRIMARY) at any age.
- 1.27 other NON-HODGIN'S LYMPHOMA of B cell immunologic phenotype: (a) small noncleaved lymphoma (Burkitt's tumor) (b) immunoblastic sarcoma.
- 1.28 any MYCOBACTERIAL disease, including tuberculosis, that is extrapulmonary and noncutaneous or disseminated, other than leprosy.
- 1.29 recurrent nontyphoid SALMONELLA septicemia & HIV
- 1.30 HIV WASTING SYNDROME. See part 2.5 of this document.
- 1.31 BACTERIAL INFECTIONS, (and combination of 2 or more within a 2 year period) of the following types in child less than 13 years of age: SEPTICEMIA, PNEUMONIA, MENINGITIS, BONE OR JOINT INFECTION, OR ABSCESS OF INTERNAL ORGAN OR BODY CAVITY (exculding otitis media or superficial skin or mucosal abscesses) caused by HEMOPHILUS, STREPTOCOCCUS (including pneumococcus) or other PYOGENIC BACTERIA.

2.0 DIAGNOSTIC METHODS.

2.1 Indicative diseases are difinitively diagnosed by histology or cytology.

2.2 Culture or antigen detection are used to diagnose the following disease: coccidioidomycosis, crytococcosis, herpes, histoplasmosis,mycobacteriosis, and other bacterial infections.

2.3 HIV enceplalopathy is defined as clinical findings of disabling cognitive and/or motor dysfunction interfering with activities of daily living, or loss of behavior developmental milestones in a child, progressing over weeks to months in the absence of a concurrent illness or condition other than HIV infection. Other illnesses can be ruled out through cerebrospinal fluid examination, brain imaging, or autopsy.

2.5 HIV wasting syndrome is defined as an involuntary weight loss of more than 10% of baseline body weight plus either chronic diarrhea (lasting greater than 1 month) or documented chronic fever and weakness (lasting greater than 1 month) in the absence of a concurrent illness or condition other than HIV infection.

3.0 EXCLUSION CRITERIA--The surveillance diagnosis of AIDS is ruled when a negative antibody test occurs, except if there is no other cause of immunodeficiency and has a disease listed in part 1.1 and a T helper cell count 400. In the absence of an HIV test, AIDS is ruled out if other causes of immunodeficiency are present, ie. corticosteroid use or some types of lymphoma.

Revised Sept 1, 1987

ADMINISTRATIVE MANUAL California Department of Corrections	TRANSMITTAL LETTER NO. AM/280
	DATE: October 5, 1987

Chapter 6100, Medical Services, of the Departmental Administrative Manual has been revised to include Section 6111. This section outlines departmental policy related to precautions for departmental staff when handling inmates who may have AIDS, ARC or HIV positivity.

Direct any inquiries regarding this matter to the Chief of Health Services at (916) 324-0876 or ATSS 454-0876.

Please see that all personnel concerned are informed of the contents of this manual addition and that it is placed into the manuals as soon as possible.

James H Gomez
JAMES H. GOMEZ
Chief Deputy Director

6111. Precautions Against Exposure to the AIDS Virus When Handling Inmates - General Guidelines for Departmental Staff

Departmental staff handling inmates who have injured themselves or have been injured in such a way that there is blood or body fluids should take reasonable precautions to prevent unnecessary exposure to the AIDS virus.

(a) Protective Apparel. Protective apparel shall be available to all staff.

(1) Protective apparel may include, but not be limited to:

(A) disposable gloves

(B) face masks

(2) A supply of protective apparel should be maintained at the institution in such a manner so as to be accessible to staff as needed.

(b) Cell and Body Searches. In order to ensure safe performance of duties involving persons suspected of or diagnosed with AIDS, staff should:

(1) Make sure their own open wounds and sores are covered with clean dry bandages to prevent possible exchange of blood; change wet bandages frequently.

(2) Wear disposable gloves when there is blood or body fluids (urine, feces, saliva, vomitus, or seminal fluid) on inmate, clothing, or linen.

(3) Avoid needle sticks or punctures with any sharp objects on the inmates body (knives, razors, or needles);

(4) Never blindly place hands in areas where there may be sharp objects that could cut or puncture the skin.

(c) Control of Inmate Disturbances, Aggressive, or Violent Inmates. Staff must assess each incident individually as to the urgency of the situation.

(1) In cases which are not life threatening, sufficient time exists to develop a plan of action and put on protective apparel.

(2) In an emergency situation, the initial on-scene staff member will assess the need for other responding staff to wear protective apparel.

(3) In cases where an inmate is combative or threatening to staff and blood is present, protective apparel will be worn.

(4) Immediately wash with soap and warm water any bites or wounds that draw blood; have them documented and treated by a physician.

(d) Responses to Homicides and Suicides. In all cases, staff shall wear disposable gloves and use a disinfectant solution of household bleach, diluted to 1:10, to clean up blood or other body fluids.

(e) Cleaning of Blood or Other Body Fluid Spills. Contaminated equipment and supplies shall be cleaned in the following manner:

(1) Wear disposable gloves and use a disinfectant solution of household bleach, diluted to 1:10, to clean work surfaces.

(2) Contaminated clothing should be placed in a disolving bag and laundered as soon as possible in hot water, detergent, and bleach.

(3) Handcuffs, leg irons, and belly chains should be disinfected after use with hot water and disinfectant of household bleach if contaminated with blood, feces, or semen.

(4) Flashlights, crime scene kits, and other equipment that became soiled with contaminated material should be cleaned with hot water and disinfectant of household bleach.

(5) Contaminated disposable items such as gloves, mask, prongs, rags or other material shall be placed in plastic bags before being thrown in trash containers.

(f) Suspected Exposure. Any staff who suspects exposure to the AIDS virus from any of the following circumstances should immediately report the incident to their supervisor and seek medical attention at the facility infirmary/hospital:

(1) Exposure to body fluids, especially blood, due to a skin puncture (i.e., hype kits) or wound received in the line of duty.

(2) Splashing of body fluids, especially blood, in the mucous membranes (eyes, nose, mouth).

(3) Exposure to body fluids, especially blood, on existing wounds, sores or broken skin.

(4) Human bites received in the line of duty which break the skin and/or draw blood.

Such staff should immediately wash the areas with warm water and soap (in the case of exposure of the mucous membranes, flush the area with warm water).

Institutional medical staff shall advise the employee to report exposure to his/her private health care providers.

San Francisco
Sheriff's Department

Last Revision Before
Signature
8/12/87 - DUE 8/26/87

STANDARDIZED PROCEDURE PROTOCOL
Manual Number: XXII-1
Date: September 27, 1985
Latest Revision: August 12, 1987

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

POLICY

Forensic Services recognizes that its clients often are in high risk groups for AIDS and HIV-related conditions. Nursing staff provide services to meet the health needs of these clients while incarcerated.

PROTOCOL

DESCRIPTION: AIDS is a disease of the immune system that is caused by the Humman Immunodeficiency Virus. The disease is transmitted through direct introduction of the virus into the bloodstream. People with the disease are left immunosuppressed which makes them susceptible to certain opportunistic infections. High risk groups for the disease are people with muitiple sexual contacts, IV drug abusers and hemophiliacs. Those people in the high risk groups who are healthy and incubating the virus are probably more likely to transmit the virus than those already ill. Incubation or "carrier state" may persist for a protracted indefinite length of time prior to development of clinical HIV disease. This protocol addresses nursing action for the four stages (as recognized by the CDC) of HIV disease: primary, asymptomatic, symptomatic and AIDS.

PURPOSE: To appropriately treat and monitor AIDS in the correctional facilities. To prevent morbidity and mortality of incarcerated youth and adults.

DATA BASE:

Subjective	Clients will be identified at intake screening or during the course of their incarceration. They will present with a history of seropositivity, history of disease but currently asymptomatic or symptoms of stage 3 or 4 disease. Note and document all subjective information. Symptoms that warrant further work-up include night sweats, fevers, weight loss, diarrhea, skin lesions (pink to purple, flat or raised, blotches or lumps, usually more firm than surrounding skin and usually painless), persistent fatigue, generalized lymphadenopathy,

STANDARDIZED PROCEDURE PROTOCOL - AIDS - PAGE 2

shortness of breath, persistent dry cough, oral sores or inflammation, or dementia. Note whether the client belongs to a high risk group. There is no standard list of ARCs but related conditions may be toxoplasmosis, amoebic diarrhea, idiopathic thrombocytopenic purpura (ITP), thrush or various herpes conditions. The nurse should note the onset and duration of symptoms and/or the history surrounding diagnosis and treatment. The above symptoms may also be indicative of several other conditions.

Objective

The nurse should assess and document:

- objective observation of symptoms.
- signs of SOB, breath sounds.
- BP, temperature, pulse and respirations.
- measure current weight, ask client for usual or normal weight to note weight loss.
- CNS changes (confusion, disorientation, balance or gait disturbances).
- debilitation, cachexia; , to what extent.

Assessment

Based on previous information:

- has symptoms of HIV disease requiring further diagnostic work-up.
- reliable history of ARC (note condition).
- reliable history of AIDS (note pneumocystis, Kaposi's Sarcoma, or other diagnositic condition).

Plan

Nursing action is based on symptomatology.

- verify diagnosis and treatment with client's consent.
- if severe respiratory symptoms, severe diarrhea and dehydration; send to the Emergency Room.
- if diagnosis of AIDS, investigate possibility of release (849b2).
- place on clinic list for next clinic.
- house in general population.
- notify head nurse about client (leave note). Give name, DOB, diagnosis, symptoms and where housed.
- if diarrhea present, attempt to house with own toilet.
- if AIDS, place on HIGH RISK LIST.
- if any concern about weight loss, get weekly weight and record.
- refer all to Medical Social Work Staff.
- refer to Jail or YGC psych staff if indicated.

-make appropriate referrals as indicated in FOLLOW-UP.

Consultation

If assessed situation is problematic and plan of action unclear, consult with head nurse, charge nurse, medical director and/or physician on-call to determine nursing action.

Consult with Social Work supervisor to attempt to get these clients with verified diagnosis out of custody.

Client Education

1. Explain exam and assessment process.
2. Explain plan of action so he/she knows what to expect. Inform of Social Work referral.
3. Explain verification process and when to expect treatment to continue if in midst of treatment course.
4. If new symptoms requiring assessment are present, explain need for further assessment and give all referral information in case released.
5. Depending on facility and appropriateness, instruct:
    - -no sexual contact and/or safer sex techniques (use of condoms, alternatives to intercourse).
    - -do not share razors.
    - -do not share needles.
    - -do not acquire new tattoos as needles have probably been or will be used by others.
    - -do not share toothbrushes
    - -good handwashing techniques.
    - -use discretion while in the facility. Do not talk to other than medical staff. Maintain confidence about symptoms, condition or transmissability. Explain that releasing this kind of information could lead to unnecessary hysteria and result in hostility toward the client.

Follow-up

If client sent to Emergency Room and returns, complete follow-up as ordered on ER sheet. If no follow-up, have physician review chart and see client at next clinic. If client placed on clinic list and is not in custody at time of clinic, research whether client released or transferred to another facility in the system. If still in the

system, send chart and give verbal report to facility nursing staff.
If treatment through SFGH and needs to return to clinic appointment, arrange through facility procedure.
If a youth is released, complete referral information to client and, if consent obtained, parent or guardian.
Reinforce referral information to client verbally and in writing in case of release.
See that consult was made and completed by MSW (if in custody, for support; upon release, for referral to community agencies as indicated).

GENERAL INFECTION CONTROL GUIDELINES

The following guidelines are appropriate for this protocol as well as for other infectious or transmissable diseases.

1. Handle all patients, body fluids as potentially HIV (+).
2. Utilize good handwashing techniques before and after each direct patient contact.
3. Use gloves when coming in direct contact with blood and body fluids (including venipuncture procedures).
4. Use disposable equipment when performing medical treatments or sterilize if using multi-use instruments.
5. Protect face and eyes if in a situation where there may be gross splattering of blood.
6. Clean up blood spills with 1:10 household bleach solution. This solution is effective in killing HIV.
7. Use puncture-proof containers for needle and sharps disposal.
8. Follow policy MANAGEMENT OF INFECTIOUS WASTE (Manual number XIII-9) and procedure MANAGEMENT OF INFECTIOUS WASTE (Manual number XXII-2).

STAFF REQUIREMENTS

EDUCATION AND TRAINING:	Protocol can be utilized by 2322, 2320, 2517, 2528, and 2328. No additional training required.
INITIAL EVALUATION:	No initial evaluation is required.

STANDARDIZED PROCEDURE PROTOCOL - AIDS - PAGE 5

Problems surfacing in following protocol will be addressed through performance appraisal and counseling sessions.

CONTINUING EDUCATION

Continuing education and training in physical assessment is helpful in utilizing protocol. Additional training may be required if problems evident in utilization. Nursing staff to attend AIDS information updates to keep up with new developments.

REVIEW SCHEDULE

DATE INITITIALLY APPROVED: 11/11/85
REVISED: 8/12/87
FREQUENCY OF REVIEW: Yearly

SIGNATURES

PROGRAM CHIEF — DATE
NANCY H. RUBIN

MEDICAL DIRECTOR - JMS — DATE
ELIZABETH KANTOR, MD

MEDICAL DIRECTOR - YGC MEDICAL — DATE
JANET SHALWITZ, MD

SUPERVISOR OF NURSING SERVICES — DATE
PAMELA KETZEL, RN

APPENDIX H

HIV Antibody Test Consent Form

DOH 3276
7/86

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH
BUREAU OF CORRECTIONAL HEALTH SERVICES

CONSENT TO TEST FOR HTLV-III VIRUS ANTIBODY AND DISCLOSURE PER INMATE REQUEST

1. I, ______________________________, ______________________________
Name Inmate Number

am requesting the Division of Health, Bureau of Correctional Health Service, perform the blood test on me to screen for the presence of the antibody to the human virus HTLV-III, which virus can cause Acquired Immune Deficiency Syndrome (AIDS). I have also been advised that the procedure, which involves the withdrawal by needle of a small amount of blood for laboratory testing, has minimal risks, such as bruising, soreness, and a slight risk of infection. I have received and read a copy of "Information Regarding HTLV-III Antibody Testing and Disclosure" which explains AIDS and the HTLV-III antibody test.

2. I understand that the results of the HTLV-III antibody test will be placed in my medical record and persons involved in my direct care will have access to this information.

3. I have been informed that the HTLV-III test results are considered confidential. I have been informed by the Health Service Unit Staff that the test results in my institutional medical record shall not be released without my written permission, except to individuals and organizations that have been given access by State law. I understand a list of individuals and organizations who may receive my test results and circumstances under which disclosures of test results may occur, is available to me. I have been informed that all of these individuals and organizations are also required by State law to keep my medical record information confidential.

I understand that the Bureau of Correctional Health Service Unit where I am having this test done will be receiving the test results, and per Department of Health and Social Service Policy, only if I am found to be diagnosed with HTLV-III infections, will information concerning me be shared with the Institution Superintendent, ______________________________, and his/her legal designees, the Institution Program Review Committee Coordinator, ______________________________, the Institution Health Services Unit Staff, the Director of the Bureau of Correctional Health Services, and designated Bureau Staff, and the State Epidemiologist and his/her designated staff. In unusual circumstances, the Secretary of the Department of Health and Social Services, the Administrator of the Division of Health, the Administrator of the Division of Corrections, and their designees may also be notified if I am found to be diagnosed with HTLV-III infections, and the Institution Superintendent believes such a notification is necessary.

Further, I authorize the following additional person or agency, if any, to access my HTLV-III antibody test results:

Name of Person/Agency Date Valid To

Name of Person/Agency Date Valid To

Name of Person/Agency Date Valid To

Signature of Inmate Inmate Number Date

4. Any questions I have regarding this test and the consequences of placing the test results in my medical record have been answered to my satisfaction.

5. I acknowledge that I have read this consent form and discussed it with the Health Service Unit Staff. I have been given the opportunity to ask questions concerning the blood test for antibodies to HTLV-III, and my questions, if any, have been answered to my satisfaction. I understand the limitations of this testing procedure and the legal and emotional risks of taking the test. Accordingly, I do consent freely and voluntarily to the performance of the HTLV-III antibody test for me.

Signature of Inmate Inmate Number Date

*U.S. G.P.O. 1988-202-045/80033